Section 1: Transformation and Quality Program Details

(Complete Section 1 by repeating parts A through F until all TQS components have been addressed. For full TQS requirements, see the TQS guidance document.)

A. **Project short title**: Establishing Housing Infrastructure

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project

If continued, insert unique project ID from OHA: 415

B. **Components addressed**

i. Component 1: Social determinants of health & equity
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this is a social determinants of health & equity project, which domain(s) does it address?
☒ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this is a CLAS standards project, which standard does it primarily address? Choose an item
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

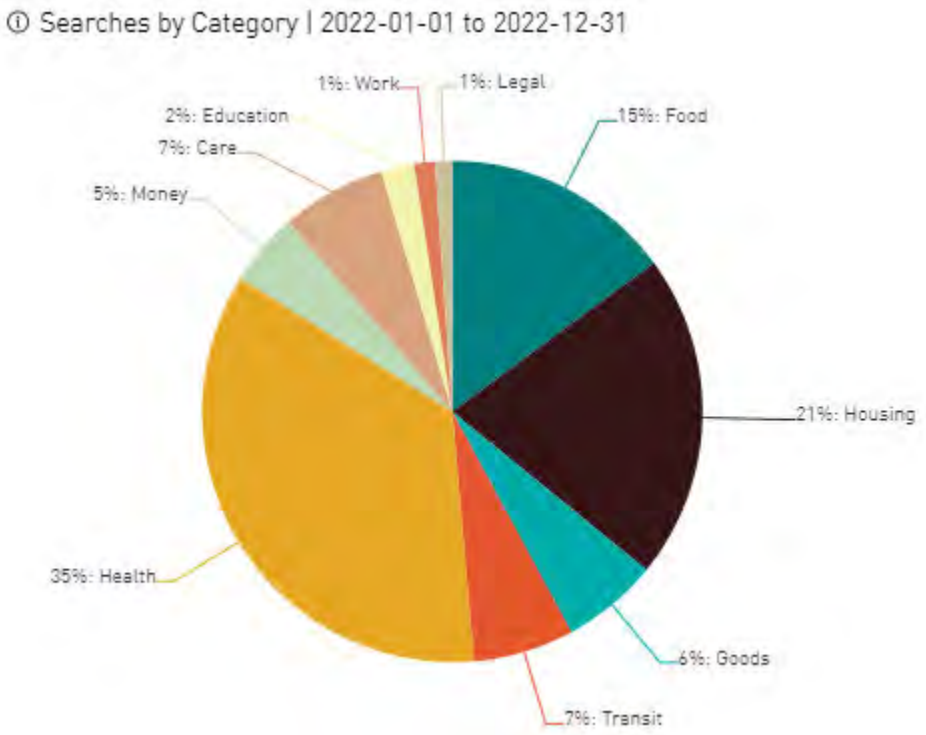
In 2022, the domain social determinants of health & equity were a component for OHA Project #415, Establishing Housing Infrastructure, a project continued for 2023.

Outside of SDOH efforts related to Housing, Sanford Children's Clinic collaborated with the Healthy Klamath Coalition (comprised of over 50 local Community Benefit Organizations, health providers, Klamath County Public Health, and CHA) to create an on-site food pantry for patients and their families. All families that screen as food insecure can leave the clinic with a bag of food and a gift card to a local grocery store. The program continued in 2022, and hygiene products, helmets, and car seats were provided to families in need as well. Additionally, varying community organizations host Produce Connection year-round making inexpensive food available to CHA and other community members. Produce Connection is a community-wide program offered through the Lake and Klamath Counties Food Bank offering fresh produce on a weekly basis and locations vary by season. Approximately 1.3 million pounds of food is distributed annually to 22,000 individuals, including 1,500 families, from this program.

Additionally, CHA is one of the "Core Four" agencies that serve as the guiding force behind the Healthy Klamath partnership which is a coalition (Healthy Klamath Network) comprised of over 50 local CBOs, health providers, and Klamath County Public Health who collaborate at every opportunity to improve the health of the community. CHA and community partners continued to utilize FindHelp, a Community Information Exchange (CIE) platform dba Healthy Klamath Connect (HKC) and formerly named Aunt Bertha. HKC functions as a central repository for the listing and availability of resources and services options for all community members (including CHA members) addressing SDOH needs. There are over 150 local community-based organizations offering services in Klamath County in the online platform offering over 200 programs for goods and services ranging from clothing, medical supplies, and food to housing advice, temporary shelter, transit services, and advice related to housing, money, work, and legal needs. HKC can be used as a closed-loop referral system when programs have been claimed by the CBOs that run them. When a CBO claims their program, they gain access to a user interface that allows the staff to manage the referrals they receive and the referrals they send to other programs on behalf of their clients. CHA staff have a specific user interface to assist with

managing CHA members based on captured SDOH in HKC and (CHA's Case Management platform). HKC also functions as a social-needs referral platform to connect members to SDOH resources. During the 2022 calendar year, the Klamath Falls community used HKC for 3,811 searches and 165 referrals for social needs services to aid in a variety of searched topics. As shown in Figure 1, health, housing, and food were the top three categories for searches. CHA and community partners also continued participation with the local Southern Oregon Health Information Exchange (HIE), Reliance eHealth Collaborative (Reliance eHealth). Reliance eHealth has some SDOH reporting which includes housing and food insecurities. CHA shares 837 data files with Reliance eHealth, and some other healthcare organizations share SDOH data from their electronic health records (EHRs).

Figure 1



CHA completed multiple training and awareness activities related to HKC in 2022. CHA brought awareness to social services and CBOs through training opportunities and direct outreach. In partnership with FindHelp, CHA hosted four HKC trainings for community partners during 2022. Topics include how to claim program, how to use platform once program is claimed, how to help community members use platform as a search tool and self-referral platform, reporting capabilities, and closed-loop referral capabilities. For the Intro to Healthy Klamath Connect 101 training held on April 4, 2022, 33 community partners completed the training. For the Intro to Healthy Klamath Connect 201 training held on April 25, 2022, 18 community partners completed the training. For the Intro to Healthy Klamath Connect 101 + 201 training held on September 26, 2022, 5 community partners completed the training. And, for the Intro to Healthy Klamath Connect 101 + 201 training held on December 7, 2022, 21 community partners completed the training. CHA made sure clinical providers and community members were aware of Healthy Klamath Connect during meetings and the annual provider network training. All new member packets include a Healthy Klamath Connect flyer. CHA passed out flyers at community events. Both the Healthy Klamath website and CHA website have links to the Healthy Klamath Connect page. CHA is leading activities related to Healthy Klamath Connect are included in the health promotion: access to care focus area of the 2022 Klamath County Community Health Improvement Plan (CHIP). CHA intends to ramp up outreach efforts in 2023. Efforts related to Healthy Klamath Connect directly aligns with the HIT Roadmap.

In addition to the Healthy Klamath Network, CHA leads and participates in numerous community groups (partnerships, meetings, committees, workgroups, etc.) that focus on social determinants of health and health equity for Klamath County. These groups included, but are not limited to, Community Advisory Council (CAC), Community Health Assessment and Community Health Improvement Plan (CHIP) leadership team, Healthy Klamath Network and CHIP workgroups, Hispanic Health Committee, Klamath Promise, Community Housing Plan Meeting, Faith Based Core Group, Community United Network Resources (CURN), Lake and Klamath County Collaborative, Systems of Care (SOC) Committee, and Klamath and Lake Counties Area on Aging (KLCCOA) Advisory Council. Refer to the TQS project Cultural and Linguistic Services Provision (CLSP), OHA Project #33, for full descriptions of these groups. CHA had identified there are a couple local programs to support the LGBTQ+ community. Current efforts primarily support youth. CHA has not yet figured out how CHA will participate in efforts to support the LGBTQ+ population. Once CHA starts collecting SOGI data, CHA will have more insight into CHA's LGBTQ+ population and will have a better understanding of what CHA's role is at that time.

CHA also participates in community health and resource fairs, outreach events, and community vaccine clinics. At these events, CHA provides informational and educational materials to community members. Multiple of such events are held monthly in the Klamath service area. Additionally, CHA provides financial support to the community through the SHARE Initiative and Health Related Services (HRS). Both the SHARE and HRS funds support Community Benefit Initiatives that align with the HEP. The HRS Flex Funds support individual CHA members who face challenges in attaining their optimal health outcomes. In November 2021, a Klamath County Motel 8 and RV park was converted to serve the community as transitional housing in the latest completed work of Project Turnkey. While the bulk of funds for this effort came from a one-time state grant through the Oregon Community Foundation, CHA also committed $75,000 in funds from its SHARE program to provide continued support for this project. The facility will be used to address housing needs for vulnerable populations; including, but are not limited to, the recently incarcerated, those in need of quarantine, and/or those displaced by wildfire damage.

Through the Healthy Klamath Network, Klamath County has a shared Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) that is developed every three years. The foundational CHA/CHIP leadership in Klamath is comprised of the "Core Four" agencies: Cascade Health Alliance (the CCO), Klamath County Public Health, Klamath Health Partnership (the Federally Qualified Health Center), and Sky Lakes Medical Center (the hospital). The Cascade Health Alliance representative facilitated listening sessions in multiple towns in Klamath County for the current cycle of the CHA/CHIP. The Klamath County Community Health Assessment 2021 was finalized on April 15, 2022. The Community Health Assessment was not finalized in 2021 due to delays related to COVID-19 and limited bandwidth from competing priorities caused by the pandemic. Numerous assessments and data sources contributed to the Klamath County Community Health Assessment 2021, including a community health assessment survey. A total of 1,058 people completed the 2021 community health assessment survey, up from 500 for the 2018 assessment. Work with Klamath Tribal Health & Family Services saw a larger population of Indigenous people participate in 2021.

The Klamath County Community Health Assessment 2021 advised the development of the Klamath County 2022-2025 Community Health Improvement Plan (CHIP). Identified as strategic health issues, the following are focus areas of the CHIP: food insecurity, hunger; health promotion: access to services; mental health; physical activity; substance use; and equity. The following identified as watch list items: access to care; chronic illness; clean air; drought; healthcare cost, housing availability, cost; maternal & child health; oral health; overall health; physical health; social isolation; trauma, chronic stress; and wildfire. Strategic health issues and watch list items were all identified as problematic areas. After a vote, the strategic health issues were chosen as priority areas and the watch list items were deemed important to track but were not chosen as CHIP projects.

CHA's Community Advisory Council (CAC) participates in the Community Health Assessment and CHIP process. The CAC is also provided regular updates on CHIP progress, so they can contribute. The CAC serves as a representational voice of CHA membership. CHA regularly seeks input from the CAC on SDOH topics, including housing.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

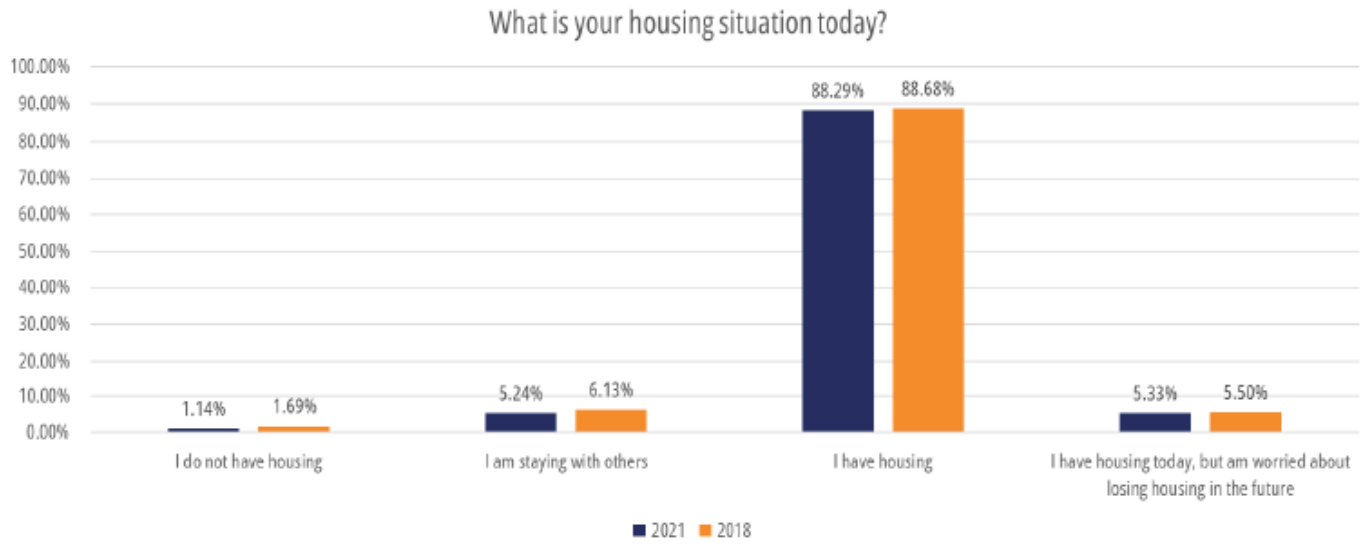
The need for safe, affordable, and efficient housing in Klamath County has been identified in several studies and has been the topic of conversation and efforts among community partners for several years. SDOH, including secure and adequate housing, impact mental health, overall wellbeing, and life expectancy. With a focus on addressing SDOH and improving economic stability, housing has not only been a priority of CHA's CAC but was also identified as a watch list item in the Klamath County 2022-2025 Community Health Improvement Plan (CHIP). During the completion of the 2023 TQS submission, CHA's CAC recommended the SDOH TQS project should continue to focus on housing in 2023. In 2022, CHA aimed to continue transforming Oral Health Integration through the following three activities:

- **Activity 1:** Community Collaboration
- **Activity 2:** Funding
- **Activity 3:** Project Research and Proposals

Progress of these activities are described in the narrative below.

According to the Community Health Assessment Survey completed for the 2021 Community Health Assessment, about 12% of respondents did not have housing or were worried about housing when asked "What is your housing situation today?" as shown in Figure 2 from the 2021 Community Health Assessment.

Figure 2



Additionally, CHA continued to use multiple methods to monitor how Klamath County is doing with addressing housing concerns. As designated by the Census Bureau, 19.1% of all Klamath County residents live below the poverty line, well above the national average of 11.6%. (Source: census.gov). According to the 2022 County Health Rankings with data as of 2018, 19% of Klamath County households face severe housing problems by having at least with at least one of the following four housing problems: overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities. This is compared to 19% for Oregon and 17% for the United States. U.S. Department of Housing and Urban Development (HUD) classifies families spending over 30% of their monthly income on housing as 'cost burdened', and housing expenses of over 50% of income is considered a 'severe cost burden'. The Conduent Health Communities Institute's American Community Survey shows in 2020 51.9% of Klamath County renters spend 30% or more of household income on rent. This is higher than 50.6% of Oregon renters and 49.1% of United States renters. Of four age groups (15-24, 25-34, 35-64, and 65+) in Klamath County, the 35-64 and 65+ age groups have the highest rate of individuals who fall into this

category with rates of 55% and 55.8% respectively. As of 2020, 17% of Klamath County households spent half or more of their income on housing according to the 2022 County Health Rankings while 15% of Oregon households and 14% of United States households faced a similar burdened. According to the Oregon Housing Alliance 2020 report, 1,730 affordable housing units are needed to meet the need of the extremely low-income community members in Klamath County.

CHA regularly and actively participates in a monthly Community Housing Plan Meeting organized by Klamath and Lake Community Action Services (KLCAS). This meeting brings together multiple community partners from various sectors. The meeting's purpose is for planning, collaborating, leveraging funding, and increasing resources to support the need for safe, affordable, and efficient housing in Klamath County. Community partners include, but are not limited to, KLCAS, Klamath Housing Authority (KHA), Klamath Tribes, Klamath Basin Behavioral Health (KBBH), Transformations Wellness Center (TWC), Klamath County Public Health, City of Klamath Falls, Sky Lakes Care Management & Wellness, Red is the Road to Wellness (RRW), Klamath Works, Klamath County Economic Development Association (KCEDA), and Veterans Enrichment Center (VEC). The meeting creates a place for community partners to discuss current activities and additional data sources while solidifying a team to work together in a solutions-based way for betterment of Klamath County.

Led by KLCAS, the Community Housing Plan Meeting group developed the Community Housing Plan for Klamath County. The planning effort brought community partners together, engaged community members to gather their feedback, reviewed available data, and developed a community-wide plan to increase housing resources. In August 2021, the Oregon Health Authority (OHA) released a funding opportunity focused on planning how best to support elimination of behavioral health inequities. KLCAS was awarded funding in September 2021 after submitting a response committing to collaborating with community partners and creating a community-wide plan to address the housing needs in Klamath and Lake counties with the understanding that no one organization can tackle the development of housing resources alone. In November 2021, KLCAS started to engage community partners and began identifying data sources. A community housing survey was created in January 2022 and an online media campaign targeting communities in Klamath County was developed and distributed in March and April 2022. Based on the survey results, the top three housing needs are affordable rentals, middle-income housing, and low-income housing. The top three effects of additional housing are: positive effect on Klamath County's economy which would provide more job opportunities, increase in home value, and increased property taxes. The survey also showed:

- 89.4% answered that Klamath County needs more housing.
- 75% said that additional housing will positively affect them and their family.
- 56% of community members said that some combination of updating town codes, Habitat for Humanity and a multi-agency housing plan was needed to meet Klamath County's housing needs.

The survey results are clear, more housing of different types and for different income levels is desired by the members of these communities.

There are multiple potential funding streams related to housing in Klamath County. These streams include, but are not limited to, U.S. Department of Agriculture (USDA) Rural Development grants and loans, Supporting Health for All through Reinvestment (SHARE), Community Benefit Initiatives (CBI) funds from Health-Related Services (HRS) dollars, city and county government, The Sky Lakes Foundation, local businesses, and the various funding sources for social services and community benefit organizations (CBOs) in the housing sector. The Community Housing Plan Meeting group intends to better utilize available dollars to make a larger impact on improving current state.

Through discussions with the Community Housing Plan Meeting group and one on one conversations with KLCAS and KHA, additional gaps and barriers were identified. The improvement opportunities include:

- One of the largest barriers for renters is application fees and deposits.

- KLCAS can offer higher dollar amounts for move in assistance and eviction prevention than the amount KHA can offer for long-term HUD assistance. This allows some people to get into a rental, but they cannot afford to keep the rental.
- Many rentals cost more than the Fair Market Rent assistance HUD can provide.
- Rentals can fail inspection for rental assistance by having something wrong with the home (i.e., broken smoke detector or window). The landlord may not want to cover repair costs, and the renter does not have the money to fix the item. So, assistance cannot be provided for the renter to rent the available rental.
- There is very limited, if any, assistance to furnish and supply a home with essentials.
- There is not a communitywide housing or SDOH navigator or care coordinator. Many people could use assistance navigating resources.
- Sustainability and self-sufficiency can be difficult due to limited funds, limited understanding, unwillingness to learn, etc.
- Limited funding is available for some types of classes.
- Often there are underlying factors for why someone does not have a place to live. These factors include, but are not limited, to behavioral health, lack of job, lack of transportation, and limited knowledge related to budgeting or advocating for themselves.
- Limited supply of housing.

Also, through those talks, CHA identified potential areas where CHA can contribute to housing efforts:

- CHA could function as a convener by bringing the housing and medical community to the same table.
- CHA could help organize a housing or SDOH care coordination meeting amongst key partners.
- CHA could provide funds through SHARE and/or CBI.
- CHA can continue to fund Healthy Klamath Connect (HKC) and increase awareness about the platform. HKC can be utilized as a forum to show the availability of rooms and funding for individuals.

CHA and the Community Housing Plan Meeting group completed a gap analysis in 2022 and made substantial progress in forming a strong team and laying the groundwork to move the housing work forward. Despite strong efforts, additional new projects and funding streams have not yet been identified. The development and implementation of new projects will be a primary focus of 2023.

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

With the growing need for housing interventions to improve SDOH factors in Klamath County, CHA is continuing collaborative efforts in 2023 to expand its partnerships with local community organizations and its involvement in community housing projects. To expand CHA's footprint on local housing work, an internal task force has been put together to identify several key factors to support community efforts for combatting housing insecurity. This task force has four primary objectives:

- Forge partnerships with agencies, businesses, and CBOs around housing work and get involved in existing projects with these partners.
- Develop funding for housing projects through grant research, cost sharing with partners, and other revenue streams.
- Develop new projects that can be ready to go when funding becomes available, or that will serve as the basis for funding requests.

- Explore the utilization of Healthy Klamath Connect as a forum to show the availability of rooms and funding for individuals. [New activity for 2023 TQS.]
- Identify outcome measure that best monitors ongoing initiatives. [New activity for 2023 TQS.]

Additional collaboration with community partners will occur in areas this work intersects with like the CHIP, SDOH Screening and Referral Incentive Metric and related performance improvement project (PIP), Behavioral Health Plan, Systems of Care, and the Health Equity Council priorities.

To ensure that member feedback remains a critical component of CHA's work, the task force will bring projects to the CAC for review and solicit suggestions and feedback from the entire community. Where possible, CHA will attempt to engage CBOs and community groups involved in discussions centered around communities experiencing historical or contemporary injustices such as racism or other systemic bias as these factors can weigh heavily on housing outcomes.

F. **Activities and monitoring for performance improvement**:

Activity 1: Community Collaboration – Expand CHA's housing partners by engaging local businesses, agencies, and community-benefit organizations (CBOs) to include CHA in their existing housing work or establish new projects in collaboration with CHA.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Number of community partners who have agreed to work with CHA on housing-related projects.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
12 community partners	14 community partners	12/2023	16 community partners	12/2024

Activity 2: Funding - Explore housing funding options in Klamath County through grant research, health-related services (HRS), or other capitol streams.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Dollar amount of new funds acquired or allocated for housing-related work.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
$0	Initial funds needed to start at least one project	Start date of first selected project	Total cost of all current projects (will change as projects are added)	Target date based on project implementation dates

Activity 3: Project Research and Proposals – Explore scope of community needs and establish potential projects to address them.

☒ Short term or ☐ Long term

Monitoring measure 3.1	Number of new vetted projects awaiting funding and implementation.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0 vetted projects	1 vetted project	06/2023	2 vetted projects	12/2023

Activity 4: Healthy Klamath Connect – Explore the utilization of Healthy Klamath Connect (HKC) as a forum to show the availability of rooms and funding for individuals.

☒ Short term or ☐ Long term

Monitoring measure 3.1	Completion of exploration and implementation if HKC has applicable capabilities			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Claimed programs can set their status as open and closed to referrals based on funding availability	Exploration completed to see if room availability can be included and if funding availability is standardized	06/2023	HKC enhancement implemented if HKC has applicable capabilities	12/2023

Activity 5: Outcome Measure – Identify outcome measure that best monitors ongoing initiatives.

☐ Short term or ☒ Long term

Monitoring measure 3.1	Completion of exploration and implementation if HKC has applicable capabilities			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No outcome measure(s) identified	Outcome measure identified	12/2023	Outcome measure implemented	06/2024

A. **Project short title:** Medical Dental Integration

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project

If continued, insert unique project ID from OHA: 364

B. **Components addressed**

i. Component 1: Oral health integration
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education

☐ Neighborhood and build environment ☐ Social and community health

vi. If this is a CLAS standards project, which standard does it primarily address? Choose an item

vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

In 2022, the domain Oral health integration was a component for OHA Project #364, Medical Dental Integration, a project continued in 2023.

Outside of the Medical Dental Integration project activities described in section D, additional work towards oral health integration occurred in 2022. Sanford Children's Clinic and The Children's Clinic of Klamath Falls both continued performing fluoride varnish and oral health screenings in their primary care offices. Both pediatric clinics received fluoride varnish training in 2021 from Cascade Health Alliance's (CHA's) contract Expanded Practice Dental Hygienist (EPDH), Konnect Dental Kare. The oral health screenings in the pediatric clinics generate referrals to additional oral health care services at the children's primary care dentist. While the referrals are not currently created using a Health Information Exchange (HIE), the traditional referral processes remain generally effective and as more dental clinics adopt the local Southern Oregon HIE, Reliance eHealth Collaborative (Reliance eHealth), there will be more opportunities to use the HIE for referrals between primary medical care and primary dental care. Also, Klamath Health Partnership (KHP) dba Klamath Open Door (KOD), a Federally Qualified Health Center (FQHC), continued functioning as a fully integrated clinic offering physical, oral, and behavioral health services at one location. For patients with greater behavioral health needs, KHP has a primary care provider co-located at Klamath Basin Behavioral Health (KBBH, Community Mental Health Program (CMHP)) who can assess for physical and oral health needs and refer patients to KOD's main clinic for treatment if needed. They remain a pillar of integration demonstration in the basin.

Dental providers in CHA's network are located within the city of Klamath Falls, making transportation for those living in outlying areas a potential limitation and concern. "Free Dental Days" are typically held one time per year in the outlying areas of Merrill and Malin and are staffed by Konnect Dental Kare (KDK, operated by an Expanded Practice Dental Hygienist (EPDH) who provides screenings and preventive services primarily to children through a contract with CHA) and other local providers. In 2022, "Free Dental Day" activities served nearly 80 patients with approximately $18,000 in the value of services provided. While these clinics offer treatment to those who would otherwise not be able to easily access oral health care, it still requires the patient to travel to a commercial hub for services. This limits the availability of oral healthcare for individuals living in remote areas of Klamath County.

In 2022, KDK participated in five community outreach activities (including "Free Dental Days") and completed preventative dental work for over 1200 children ages 1-14 in a variety of locations throughout the region. KDK has recently acquired a trailer capable of supporting dental equipment and it is in the process of being outfitted as a mobile workspace. Once completed, this will further improve KDK's ability to provide services to our more rural membership.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

The Oregon Health Authority (OHA) identified three high risk co-morbidities amongst the Oregon Health Plan (OHP) membership: Hypertension, Diabetes, and Tobacco. With the recent formation of a Medical-Dental Integration Partnership by the Center for Disease Control's Division of Oral Health, there is momentum among the healthcare community to broaden screening capabilities for patients with chronic diseases. In 2022, CHA aimed to continue transforming Oral Health Integration through the following three activities:

- **Activity 1: HIE Integration**
- **Activity 2: HIE Screenings & Referrals**
- **Activity 3 : KDK Partnership**

Progress of these activities are described in the narrative below.

Within Klamath County's local healthcare system, the use of multiple, different electronic health records among the provider network, as well as lack of use of the available HIE, Reliance eHealth, has created a challenge for full integration of the healthcare system, particularly among the dental community. While the network's dental providers utilize CHA's web-based portal for authorization submittal, only one oral health provider, KOD, is currently utilizing Reliance eHealth for purposes of data sharing through the Community Health Record, with no dental providers utilizing Reliance eHealth to send referrals to members' primary care providers. The lack of dental providers utilizing Reliance eHealth also makes primary care submittal of referrals to dental providers less efficient. This deficiency presents an opportunity to improve services provided to our members and further move the healthcare system toward integration of services across provider types.

Integrating all providers into the HIE is intended to improve the ability for referrals and screenings in primary care and dental settings, allowing a swift two-way communication between both provider types. With the challenges in 2021 of integrating the OIT Dental Clinic, the goal for 2022 was simply to get at least one additional oral healthcare provider utilizing Reliance, and another in 2023. Staffing challenges at local clinics, coupled with an increased demand for services as pandemic concerns waned, led to difficulty dedicating time to this endeavor. We will revise our targets for this activity in light of the current environmental conditions.

Similarly, the second activity in this project was to develop and implement several workflows to improve referrals and screenings in non-standard settings. Continued staffing challenges and increased demand for services also affected this project as the intent was to begin with a survey of providers ability and willingness to engage in referral activity across the Medical/Oral divide. This was to be reinforced by development and demonstration of the Reliance HIE as a medium for such referrals. Neither of these critical first two steps were completed in 2022, but we feel there is still a need to identify both a process for, and a willingness to engage in, medical care referrals originating in an oral care setting. We will revise targets for this activity as well.

While work in the HIE and referral sector was slow to get moving, efforts to help KDK grow into a more robust non-traditional dental solution for the basin moved quite quickly. In 2022, KDK staff increased from 2 to 4 team members which exceeds our target for the year. Additionally, while we'd hoped to help KDK get partnered with at least one Primary Care Clinic to provide dental services in a primary care setting, KDK managed to stand up relationships with two: Sanford Children's Clinic and Cascades East Family Practice. Work in these partnerships involved collaboration on Well Child Visit Days and other community collaboration support. Since KDK had already built a relationship with one local dental office, the goal in 2022 was to increase this cooperation by adding at least one more partner dental clinic that could utilize KDK's more mobile operation features. To help ensure efficient gap closure of the Oral Evaluations for Persons with Diabetes OHA metric, KDK worked with Klamath Dental Center and Klamath Health Partnership Dental Clinic. Continued collaboration with Timber Kids became a mainstay as well. While KDK hadn't had as much association with Advantage this year, that still remains a clinic with good ties to the resources KDK provides, bringing the total partners to four (4). As this represents all of the large primary care dentists in the community, monitoring measure 3.3 will be retired as no further significant progress is possible.

We will continue to work with KDK to achieve our goals for health equity and access in Klamath County.

After reviewing REALD data for KDK activity from 2020 through 2022, I do not see any trends that indicate a particular need to change direction with how we're engaging this resource. While work with self-identified racial minorities has

increased slightly, work with disabled members has reduced. These slight variations do not appear to be significant or tied to provider behavior.

New in 2023, CHA will develop a plan to collect sexual orientation and gender identity (SOGI) data during member onboarding and to stratify dental and other quality data by it once collected.

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

Despite the staffing challenges faced in 2022, CHA will continue to partner with local oral health providers within its network to fully implement Reliance eHealth for purposes of data sharing between all participating provider types (primary care, oral health, behavioral health, and others) and referrals based on screening outcomes. Once the HIE is established as a referral resource, additional exploration of disease screenings and cadence will be pursued. Additionally, Reliance eHealth is being considered as a platform for 2023 work on SDOH screening and referrals. Any work to increase the utilization of this platform will support those goals as well.

To improve the value of the Reliance eHealth system, CHA will continue developing ways to showcase how the platform can improve workflows and provide better care through seamless referrals between provider groups. This will require partnering with existing users of the platform to document usage paths that can be highlighted in provider onboarding. This will be coupled with identifying providers capable of completing screenings and both referring to, and being referred by, other users of the platform as adoption increases.

With staffing and partnerships increased, KDK should continue its integration with Reliance eHealth. As this connectivity is established, KDK's mobile and flexible services will be able to serve, not only as a platform for oral health care outside of traditional dental offices, but also as a means of disease screenings and referrals to primary care. CHA will continue to explore funding for the expansion of KDK and implementation of their services in partnership with existing primary care providers as either a mobile dental resource or as a dental resource co-located in a primary care setting. As KDK works to finish outfitting their dental trailer, CHA will look for the best ways to utilize this new resource? One challenge that KDK has faced is limitations on available reviewers to submit claims based on the evaluations done for the community. KDK is looking for a dentist that can join their staff to facilitate such integration, and CHA will help in the search as well.

F. **Activities and monitoring for performance improvement**:

Activity 1 – HIE Integration: Dental providers integrated into Health Information Exchange (HIE), Reliance eHealth

☐ Short term or ☒ Long term

Monitoring measure 1.1	Onboard dental providers to the Reliance eHealth platform			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
1 network oral health provider currently utilizing Reliance eHealth in 2023	+1 network oral health provider utilizing Reliance eHealth to its full capacity (total of 2)	12/2023	+2 network oral health provider utilizing Reliance eHealth to its full capacity (total of 3)	12/2024

Activity 2 – HIE Screenings & Referrals: Development of workflow for preventive medical screenings and referrals via Reliance eHealth by oral health providers.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Workflow for external referrals researched and documented.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Referral workflow not created	Referral workflow researched with existing providers and documented	09/2023	Referral workflow added to dental HIE onboarding process	12/2023
Monitoring measure 2.2	Oral healthcare ability to perform medical screenings.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
% Of Oral Healthcare providers able to deliver screenings is unknown.	Survey Oral Healthcare providers on ability and willingness to perform medical screenings.	09/2023	At least 50% of Oral Healthcare providers able to perform medical screenings.	12/2024
Monitoring measure 2.3	Primary Care Providers able to receive and act on referrals from Oral Healthcare providers.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
% Of Primary Care Providers able to receive referrals from Oral Healthcare is unknown.	Survey Primary Care Providers on ability and willingness to receive and act on referrals from Oral Healthcare.	09/2023	At least 70% of Primary Care Providers able to receive and act on Oral Healthcare referrals.	12/2024

Activity 3 – KDK Partnership: Expand Klamath Dental Kare (KDK) as a mobile, non-traditional setting, oral healthcare resource

☐ Short term or ☒ Long term

Monitoring measure 3.1	KDK Licensed Oral Health Staff			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
4 staff members as of March 2023 (originally 1 at start of measure)	2 additional staff members in training (completed in 2022)	12/2022	2 additional staff members working in their full scope (working towards 2023 completion)	12/2023
Monitoring measure 3.2	KDK Primary Care Partner Organizations			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**

2 primary care partners (was 0 at start of measure)	1 additional primary care partner up to 3	12/2023	2 additional primary care partners up to 4	12/2024

A. **Project short title**: Closed-loop Grievance System

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project

If continued, insert unique project ID from OHA: 61

B. **Components addressed**

i. Component 1: Grievance and appeal system
ii. Component 2 (if applicable): Health equity: Data
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this is a CLAS standards project, which standard does it primarily address? Choose an item
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

In 2022, the domains Grievance and appeal system and Health equity: Data were components for OHA Project #61, Closed-loop Grievance System, TQS project, a project continued for 2023. The Access: Timely domain was included in this project in 2022; however, since OHA discontinued it as a TQS component for 2023 TQS, CHA will no longer report on current progress for this domain in TQS.

Grievance and appeal system

As shown within the attached documents, CHA has policies and procedures in place for appeals, notice of adverse benefit determinations (NOABDs), hearings, and grievances. In 2022, the Compliance Committee (a Board of Directors sponsored Committee) continues to have ultimate oversight over member grievances and appeals, including quarterly monitoring of all data and Corrective Action Plans. CHA trains staff, community advisory council (CAC), and provider network on the grievance and appeal system annually. All members have access to information regarding the grievance and appeal system in CHA's member handbook and website.

CHA has quarterly grievance, appeals, provider dismissal, and authorization denial (NOABD) dashboards. So far, the grievance and provider dismissal dashboards are stratified by race, ethnicity, and language. The appeals dashboard is next to be stratified by race, ethnicity, and language. Most of the grievance and appeal data comes from internal sources; however, TransLink (non-emergency medical transportation, NEMT, provider) and Klamath Basin Behavioral Health (KBBH) provide additional, external data. Member grievances are reviewed monthly by the Provider Network Management Committee (PNMC; composed of representatives from the following internal CHA departments: Operations, Provider Network, Quality Management, Case Management, Member Services, and Business Intelligence). Concerns raised during regular monitoring of subcontractors and/or delegated entities either through the annual audit process or regular data submission are also brought to the PNMC for review and action if necessary. In 2022, the top three (3) grievance categories were Provider/Plan (39 grievances), Access to Care (33 grievances), and Consumer Rights (16 grievances). These were the same top three (3) grievance categories as 2021 (Access to Care (44 grievances),

Provider/Plan (48 grievances), and Consumer Rights (19 grievances). The service types with the highest grievances in 2022 were: dental (32 grievances; 30% of total grievances), Primary Care Provider (PCP; 23 grievances; 22% of total grievances), and other (25 grievances; 23% of total grievances). The overall number of grievances decreased significantly from 2021 (132) to 2022 (107) with a 19% reduction overall. This decrease was likely due to more providers and clinics returning to near-pre-pandemic availability and capacity. Related to health equity, in 2022, CHA had zero grievances regarding "provider's office has a physical barrier/not ADA compliant, prevents access to office, lavatory, examination, room, etc."; however, one clinic had a grievance regarding "provider/plan bias barrier (age, race, religion, sexual orientation, mental/physical health, marital status, Medicare/Medicaid)". The grievance was from a member who felt they were not being treated with respect regarding dismissal from care. It was explained to the member that their complaint was not an issue of disrespect, but a general policy regarding missed appointments.

As far as appeals are concerned, 2022 data shows the following services accounted for the majority of appeals: specialty care (41%), dental (16%), imaging (14%), and pharmacy (11%). This differs in several places compared to 2021 where DME (9%) was nearly three times as frequent as Imaging (3%), and the opposite was true in 2022. Overall, most of the appeals and denials in 2021 and 2022 continue to be related to services that are not considered medically appropriate/necessary and denial or reduction in quantity of services. This continues to be an educational opportunity for both members and providers.

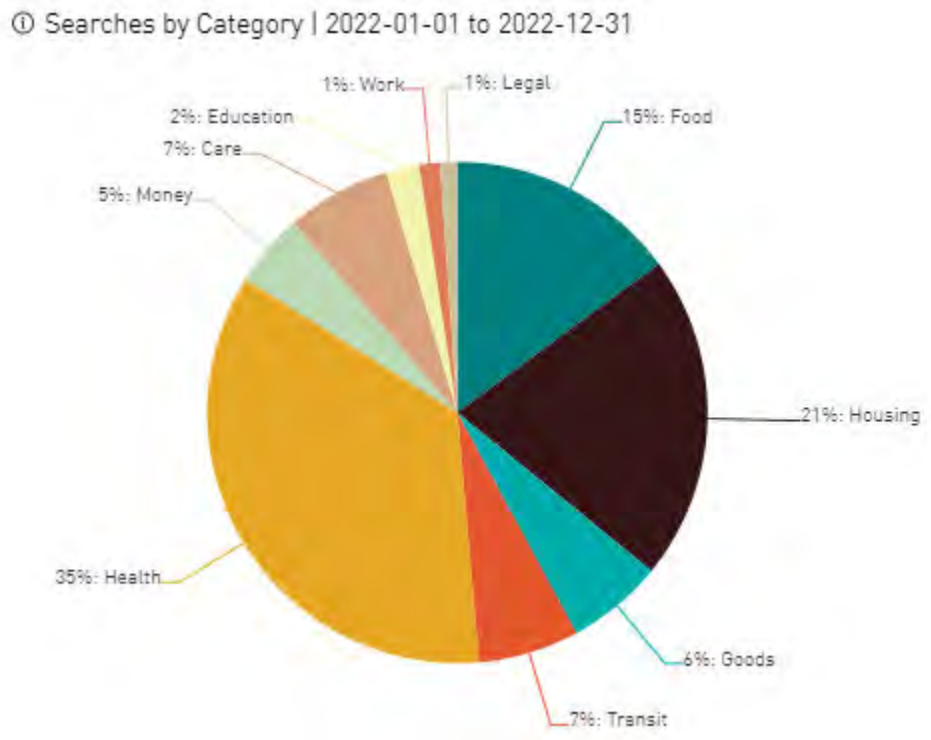
To help facilitate identifying trends of poor member experience, CHA utilized multiple sources of member experience data and reporting methods to further investigate findings found through grievance and appeal data. Data sources and reporting methods include but are not limited to: Oregon Health Authority (OHA), Healthy Klamath, County Health Rankings, Healthy Klamath Connect, CHA's Community Advisory Council (CAC), Delivery Service Network (DSN) Narrative and Capacity Report, Patient-Centered Primary Care Home (PCPCH) enrollment, service utilization and claims, and Language Line utilization. However, due to the broad nature of member experience data and its many sources, current data related to member experience is scattered amongst multiple reports, at times outdated by the time it is reported, not member or topic specific, or not easily accessible by CHA. This causes in-depth analysis of member experience data to be inefficient and potentially duplicative. Improvement opportunities include aggregation of data from multiple sources, collection of additional data points when gaps are identified, and conversion of data into more easily actionable information for use both internally and by the provider network. CHA identified these challenges and improvement opportunities in 2020 and continued working on changes in 2021 and 2022.

Health Equity: Data

CHA partners with its provider network to ensure the provision of culturally and linguistically appropriate services to members by identifying areas of opportunity, gaps in services and community resources, and correct consistent areas of member complaints. To track and evaluate member demographics, CHA utilizes a quarterly equity (member demographics) dashboard that includes REALD (race, ethnicity, language, and disability), age, gender, and marital status. CHA uses data from 834s and Reliance eHealth (the local Southern Oregon Health Information Exchange (HIE), Reliance eHealth Collaborative) to analyze and monitor REALD data. CHA continued to capture a higher percentage of REALD data in 2022. Of 25,932 members active on February 15, 2023, 36% (9,257 members) have not disclosed their race; 36% (9,222) have not disclosed their ethnicity; and 0.5% (132) have not disclosed their preferred language. This is compared to March 1 of 2022 when, of 24,207 members, 47%, or 11,290 members, did not disclose their race; 48% (11,637) did not disclose their ethnicity; and .6% (139) did not disclose their preferred language. (Early 2022 REALD data has been updated, compared to the previous TQS submission, to reflect new and more accurate data sources.) Starting September 2021, CHA included race, ethnicity, and language data in monthly member roster files sent to primary care clinics. In January 2022, CHA began regularly including this information with member rosters sent to primary dental clinics. New in 2023, CHA will develop a plan to collect sexual orientation and gender identity (SOGI) data during member onboarding and to stratify quality data by it once collected.

CHA and community partners continued to utilize FindHelp; a Community Information Exchange (CIE) platform dba Healthy Klamath Connect (HKC) formally named Aunt Bertha. HKC functions as a central repository for the listing and availability of resources and services options for all community members (including CHA members) addressing social determinant of health (SDOH) needs. There are over 150 local community-based organizations (CBOs) offering services in Klamath County in the online platform offering over 200 programs for goods and services ranging from clothing, medical supplies, and food to care coordination, housing advice, temporary shelter, transit services, and advice related to housing, money, work, and legal challenges. HKC can be used as a closed-loop referral system when programs have been claimed by the community-based organizations that run them. When a community-based organization claims their program, they gain access to a user interface that allows the staff to manage the referrals they receive and the referrals they send to other programs on behalf of their clients. CHA staff have a specific user interface to assist CHA members with their needs based on SDOH screening results in HKC and/or (CHA's Case Management platform). HKC also functions as a social-needs referral platform to connect members to SDOH resources. During the 2022 calendar year, the Klamath Falls community used HKC for 3,811 searches and 165 referrals for social needs services to aid in a variety of searched topics as shown in Figure 3. CHA and community partners also continued participation with the local Southern Oregon Health Information Exchange (HIE), Reliance eHealth Collaborative (Reliance eHealth). Reliance eHealth has some SDOH reporting which includes housing and food insecurities. CHA shares 837 data files with Reliance, and some other healthcare organizations share SDOH data from their electronic health records (EHRs).

Figure 3



To better identify and close social needs gaps, CHA has a multidisciplinary team focused on improving social determinates of health (SDOH) screening and referrals (through HKC) to improve identification of social needs to decrease health disparities for all members, including members who may not have received culturally and linguistically responsive services previously. This work is tracked through the Establish SDOH Screening and Referral Process performance improvement project (PIP) which is currently focused on infrastructure building for SDOH screening and referrals. Through the PIP, CHA is evaluating, testing, and updating current processes for social needs screening, data

capture, data sharing, and closed-loop referrals. During the process to update CHA's internal infrastructure, CHA will collaborate with local organizations and providers who are already screening members to limit duplicative efforts, establish data-sharing protocols, and increase usage of HKC for referring members to resources. CHA also utilized Social Determinants of Health (SDOH) data from other sources to identify both member level and community level needs. These data sources include, but are not limited, to Health Risk Assessments (HRAs), Klamath County Community Health Assessment, and Well-Being data through BlueZones RealAge Test.

Please see the following attached as supporting documentation for this project:

- 2022 Member Demographics Dashboard
- 2022 Grievances, Appeals, and Denials Dashboards
- 2022 Provider Dismissal Dashboard
- Appeals/Grievances 2022 Provider Training (includes Provider Dismissal of Member training)
- Grievance and Appeal System Policy and Procedure
- Provider Dismissal of Member Policy and Procedure
- Establish SDOH Screening and Referral Process performance improvement project (PIP)

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

Strengthening CHA's data collection and reporting structures, including stratification of data by REALD, continued as a high priority for CHA in 2022. More comprehensive data reporting will allow for more robust data analysis which will enable CHA to better connect members to community resources through the CIE, HKC, and provider generated resources to improve member experience with our local healthcare system.

Race, ethnicity, language, and disability (REALD) and sexual orientation and general identity (SOGI) can affect member experience and health outcomes. In 2021, CHA worked on developing a process to stratify grievances and appeals data by REALD status. This includes member reassignment and provider dismissal data captured within grievance and appeal reporting. Collection and analysis of this data may provide further insight into why members file a complaint (grievance), as well as identify additional opportunities for CHA to better serve members and improve health outcomes. Since CHA was unable to complete and implement the stratification of grievances and appeals dashboards by REALD in 2022 due to bandwidth limitations, CHA will complete implementation in 2023.

2022 Monitoring Activity Updates:

- **Activity 1 (Member Reassignments due to Provider Dismissals, Secret Shopper, and NEMT):** On July 15, 2022, CHA created a template in (CHA's Case Management platform) to improve data capture of member reassignments due to provider dismissals. Using data from this template, a SQL Server Reporting Services (SSRS) report was created on July 22, 2022, which feeds into the dashboard that was created on January 24, 2023. The report and dashboard will be automatically updated quarterly starting in Q2 2023. Currently, member reassignments due to provider dismissals are stratified by race, ethnicity, language, gender, and age range. The new dashboard will guide 2023 initiatives. Only 16.2% of CHA's contracted providers completed the virtual Provider Dismissal of Member training in 2020, 4% completed the training in 2021, and 9% (30 of 331 providers) completed the training in 2022. Clinic staff seem to complete the provider training we offer more than the providers themselves. Since there are other efforts to increase the number of providers who complete provider training, the provider training monitoring measure will not be included as part of this TQS project in 2023. Similarly, the Secret Shopper and NEMT monitoring measures will also be excluded as these were part of the discontinued Timely Access TQS domain. The Secret Shopper and NEMT efforts will continue as projects outside of TQS.

- **Activity 2 (Utilize current and new systems to improve the capture of REALD and SDOH data to increase transparency of member needs with outreach, care coordination, and planning interventions.):** CHA has a monthly, previously quarterly, member demographics dashboard and increased the capture rate of REALD data (as described in Section C). CHA continued to add disability status to the member demographics dashboard using the option code on 834s. During 2022, CHA explored other data sources to supplement the 834's disability option code to improve accuracy of reporting disability status of members as well as connecting members to needed resources. CHA opted to utilize Health Risk Assessments (HRAs) to collect disability data as CHA has an ongoing HRA project to revamp HRAs to collect additional REALD data as well as capture some SDOH and SOGI data. Additionally, CHA continued to include race, ethnicity, and language with monthly member rosters sent to primary care and dental clinics.
    - **Monitoring Measure 2.1** – As of 2/24/23 – 65.85% of members' self-identified race was collected in our systems. This meets the target for 2022.
    - **Monitoring Measure 2.2** – As of 2/24/23 – 81.00% of members' self-identified ethnicity was collected in our systems. This just meets the target for 2022.
    - **Monitoring Measure 2.3** – As of 2/24/23 – 99.48% of members' self-identified language was collected in our systems. This didn't meet the target for 2022. This only represents 136 members whose language information is not being captured and measuring this is subject to a lot of variances. As language data collection is strong, this monitoring measure will be retired.

- **Activity 3 (Create, if needed, and utilize quality reports (including, but are not limited to, all grievance types (i.e. member reassignment, provider dismissals, NEMT, etc.) and appeals data) stratified by REALD data to increase transparency of member needs for targeted member outreach, member engagement, care coordination, and education programs.):** For monitoring measures 3.1 and 3.2, CHA also made progress towards stratifying grievance and appeal reporting by REALD. Raw data was stratified by REALD and showed that historically, appeals, grievances, and denials happen significantly less with self-identified minority groups compared to the member population averages for these groups. Overall utilization by REALD has not been fully explored to identify if these Appeal, Grievance, and Denial averages are properly reflective of groups with over/under utilization. The grievance dashboard was stratified by race, ethnicity, and language. Stratification by disability is pending improved capture of member self-reported disability status. Due to bandwidth constraints, CHA did not yet stratify the appeals dashboard by REALD. CHA intends to do this in 2023. For monitoring measure 3.3, many member level reports are stratified by REALD or easily can be stratified by REALD if not already. Some dashboards are stratified by REALD. To further this work, CHA created a Health Equity Dashboard and enhanced member profile implementation plan to carry out in 2023 and 2024.

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

The Closed-loop Grievance System project will enhance the current closed-loop grievance system and enable CHA to utilize data more easily to better identify opportunities to eliminate health disparities and improve member experience, including those related to culturally and linguistically appropriate services and care. In 2023, CHA will continue working towards the stratification of grievances, appeals, and other quality data by race, ethnicity, language, and disability (REALD) through the health equity dashboard to create targeted and tailored member outreach, communication, education, and quality improvement opportunities. This process includes updates to infrastructure (policies and procedures and data capture, collection, reporting, and analysis) and building upon the partnerships CHA has developed with providers, clinics, community-based organizations (CBOs), and other community partners. CHA will utilize data from currently available sources, including KBBH and TransLink, as well as continue to invest in additional collection methods. CHA aims to improve data capture, stratification, and analysis, better use data to identify trends, and implement interventions to alleviate the barriers to care identified through data analysis. In addition to supporting this project, improved data collection will support other CHA TQS projects, including the Cultural and Linguistic Services Provision

(OHA Project #33) TQS project. Once CHA has grievances, appeals, and other quality data stratified by REALD, SOGI, and other applicable data, CHA will perform an in-depth analysis to identify improvement opportunities to eliminate health disparities provide culturally and linguistically responsive services. This project is transformative because efforts will work towards eliminating health disparities, so all community members can reach their full health potential and well-being.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): **Conduct targeted interventions using enhanced data collection and reporting capabilities that allow for better identification and analysis of root causes related to member reassignments from provider dismissals.**

☐ Short term or ☒ Long term

Monitoring measure 1.1	Establish systematic process to track all member reassignments due to provider dismissals (including dismissals that do not result in a grievance) to improve reporting capabilities			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Systematic process to capture data and dashboard created	Review all data points and consider putting some on trendlines	06/2023	Trendlines completed, if deemed necessary	01/2024
Monitoring measure 1.2	Establish systematic process to allow for stratification of member reassignments due to provider dismissals by additional other applicable factors (i.e., disability, SOGI, SDOH, SPMI, chronic disease, etc.).			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Provider Dismissal Dashboard stratified by race, ethnicity, and language	Additional factors for stratification reviewed	07/2023	Additional factors for stratification chosen and added	12/2023

Activity 2 description: Utilize current and new systems to improve the capture of REALD data to increase transparency of member needs for targeted member outreach, member engagement, care coordination, and education programs. This will guide CHA during strategic planning and developing interventions to eliminate health disparities.

☒ Short term or ☐ Long term

Monitoring measure 2.1	Amount of Member Self-Reported Race captured.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
As of 03/01/23, 66% of Member Self-Reported Race is currently captured (started as 54% in 2022)	73% of Member Self-Reported Race is currently captured (40% of missing data is captured)	12/2023	73% of Member Self-Reported Race is currently captured (40% of missing data is captured)	12/2023

Monitoring measure 2.2	Amount of Member Self-Reported Ethnicity captured.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
As of 03/01/23, 81% of Member Self-Reported Ethnicity is currently captured (initially was 76%)	86% of Member Self-Reported Ethnicity is currently captured (40% of missing data is captured)	12/2023	86% of Member Self-Reported Ethnicity is currently captured (40% of missing data is captured)	12/2023
Monitoring measure 2.4	Type of Member Self-Reported Disability captured.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
HRAs identified as method to capture Member Self-Reported Disability identified	New HRA's implemented	9/2023	Process to use Member Self-Reported Disability for quality report stratification developed and implemented	12/2023

Activity 3 description: Utilize current and new systems to improve the capture of SOGI data to increase transparency of member needs for targeted member outreach, member engagement, care coordination, and education programs. This will guide CHA during strategic planning and developing interventions to eliminate health disparities.

☐ Short term or ☒ Long term

Monitoring measure 3.1	Amount of Member Self-Reported Sexual Orientation captured.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
HRAs identified as method to capture Member Self-Reported Sexual Orientation identified	New HRA's implemented	9/2023	Process to use Member Self-Reported Sexual Orientation for quality report stratification developed and implemented	12/2023
Monitoring measure 3.2	Amount of Member Self-Reported Gender Identity captured.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
HRAs identified as method to capture Member Self-Reported Gender Identity identified	New HRA's implemented	9/2023	Process to use Member Self-Reported Gender Identity for quality report	12/2023

			stratification developed and implemented	

Activity 4 description: Create, if needed, and utilize quality reports (including, but are not limited to, all grievance types (i.e. member reassignment, provider dismissals, NEMT, etc.) and appeals data) stratified by REALD data to increase transparency of member needs for targeted member outreach, member engagement, care coordination, and education programs. This will guide CHA during strategic planning and developing interventions to eliminate health disparities. [This was Activity 3 for 2022 TQS Submission.]

☐ Short term or ☒ Long term

Monitoring measure 4.1	Utilize quarterly grievance reporting stratified by REALD and SOGI for targeted interventions			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Raw grievance data stratified by REALD. Grievance dashboard stratified by race, ethnicity, and language.	Grievance dashboard stratified by disability	12/2023	Grievance dashboard stratified by SOGI	12/2024
Monitoring measure 4.2	Utilize quarterly appeals reporting stratified by REALD and SOGI for targeted interventions			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Raw appeals data stratified by REALD. Stratifying appeals reporting by REALD is in process	Appeals Report stratified by REALD is completed	12/2023	Appeal dashboard stratified by SOGI	12/2024
Monitoring measure 4.3	Implement and utilize Health Equity Dashboard. The Health Equity Dashboard is holistic view of multiple data sources aggregated together with multiple filters. Its purpose is to identify trends or gaps to guide initiatives. The Health Equity Dashboard will use quality reports stratified by REALD and SOGI (i.e., disease prevalence, health outcomes, provider assignments, access, utilization, incentive metrics, FBDE, LTSS, SDOH, G&A, improvement project outcome measures, and other member demographics). This will guide CHA during strategic planning and developing interventions to eliminate health disparities.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Many member level reports are stratified by REALD or easily can be stratified by REALD	Health Equity Dashboard implemented	12/2023	One project based on health disparity identified from Health Equity	12/2024

if not already. Some dashboards are stratified by REALD. Health Equity Dashboard implementation plan created.			Dashboard completed	
Monitoring measure 4.4	Enhance the member profile in Essette (CHA's case management platform) to better align with data captured in the Health Equity Dashboard. The member profile is a holistic view of a member to guide person-centered care plans. Of note, the Health Equity Dashboard will likely contain some data points that will not be included in the member profile and vice versa.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Member profile has limited information about a member.	Gap analysis completed to show differences between current member profile and Health Equity Dashboard	06/2024	Enhanced member profile completed	12/2024

A. Project short title: Comprehensive PCPCH Plan

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project

If continued, insert unique project ID from OHA: 365

B. Components addressed

i. Component 1: PCPCH: Tier advancement
ii. Component 2 (if applicable): PCPCH: Member enrollment
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this is a CLAS standards project, which standard does it primarily address? Choose an item
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

C. Component prior year assessment: Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

For both the PCPCH: Tier advancement and PCPCH: Member enrollment components, CHA aligned its Improve Member Experience through PCPCH Tier Advancement performance improvement project (PIP) with the Comprehensive PCPCH Plan TQS project. These efforts are explained in Section D (project context). Outside of TQS and PIP work, CHA continues to prioritize Patient-Centered Primary Care Home (PCPCH) clinics when assigning new members and unassigned members to a primary care provider. CHA continued value-based payments for tier 3 and above to encourage clinics to

reach a higher tier-level. CHA also continued to follow established standards to ensure members receive access to integrated, culturally and linguistically appropriate patient-centered care and services (physical, behavioral, and dental) through its Patient Centered Primary Care Home Policy and Procedure (see attached).

A post-pandemic surge in utilization stressed the CHA network, pushing many clinics to capacity and affecting ability to assign members to the preferred high-PCPCH-tier providers. This resulted in a weighted score reduction to 79% from the previous year's 85%. With no changes in Tiers this year, this reduction came solely from members not being assigned to a PCPCH clinic. Of the current 25931 members enrolled with physical coverage, 91% (23699) are currently assigned to a PCPCH. While this has been a decline in PCPCH weighted score during a challenging year, it still exceeds the previously communicated statewide average from 2020 or 76%.

Please see the following attached as supporting documentation for this project:

- Draft Person-Centered Primary Care Home (PCPCH) Comprehensive Plan
- Patient centered Primary Care Home Policy & Procedure

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

2022 Monitoring Activity Updates:

- **Activity 1 (Development and implementation of PCPCH comprehensive plan and learning collaborative):** The 2022 target and benchmark dates for PCPCH comprehensive plan development and implementation will be re-extended into 2023.
- **Activity 2 (Member enrollment and weighted score):** Target missed at end of 2022. CHA will work towards regaining baseline of 85% during 2023.
- Progress is further explained below.

After discovering in 2021 that the local PCPCH clinics had little interest in a learning collaborative to improve PCPCH performance, efforts to revise the draft Comprehensive PCPCH Plan were put on hold. Limited staffing and a challenging labor market created a strain on project work when member experience and metric performance were a greater priority. As CHA and local clinic staff work to fill open positions and drive operational efficiency, efforts towards revising this plan will continue in 2023.

As the CHA provider network was facing challenges with capacity (see Section C), the normal efforts to educate members regarding PCPCH clinics were dialed back. Instead, messaging had a significant emphasis on preventative care and local events that would efficiently help the population. Member assignment to PCPCH clinics declined with a current weighted score of 79%.

PCPCH assignment data is also now being explored with a health equity lens, assignments and weighted scores being evaluated for possible disparities across race, ethnicity, language, and disability. PCPCH weighted scores among minorities is extremely close to the program average, with only a few exceptions in extremely small communities (under 50 members). We will continue to review these factors affecting health equity. As additional data becomes available, it will also be incorporated into how we examine member assignments and PCPCH status. This includes SOGI data, which CHA will begin gathering through the member onboarding process.

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

CHA will continue the development of a comprehensive PCPCH plan for tier advancement and member enrollment. As CHA currently only has 91% of its eligible members assigned to PCPCH clinics, our focus in 2023 will be to help high-tier PCPCH clinics regain the staffing capacity to accept new members. From there, the priority will be getting members established with care at the highest tier clinic available. This should restore CHA's trajectory.

The project will target current 4 Star PCPCH clinics and non-PCPCH primary care clinics contracted with CHA. Efforts will include, but not be limited to, further building relationships with non-PCPCH clinics, education to practices on the benefits of tier advancement, and providing assessment tools to determine program readiness. Despite terminating the learning collaborative, CHA will continue to offer technical assistance (TA) to any clinic that may need extra assistance or help overcoming barriers to meeting certain PCPCH standards.

Additionally, CHA will continue to monitor PCPCH and member data to improve our understanding of population care and to proactively remove disparities when identified. As CHA will begin gathering SOGI data from members this year, efforts will go into place to create robust quarterly reports that stratify PCPCH details by REALD and SOGI when available. Currently, the process is inspection-based, but CHA is working to make this into a regular report that can inform decisions in network management.

F. **Activities and monitoring for performance improvement**:

Activity 1 description (continue repeating until all activities included): Add text here **Activity 1 description** (continue repeating until all activities included): Develop and implement PCPCH comprehensive plan.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Status of PCPCH comprehensive plan.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Draft PCPCH comprehensive plan	Finalized PCPCH comprehensive plan	09/2023	PCPCH comprehensive plan implemented and established	12/2023

Activity 2 description: Increase member enrollment in higher tiered PCPCH clinics through supporting 4 Star clinics advancement to 5 star and working with non-PCPCH clinics to become PCPCH clinics. (Modified 2021 Activity 3)

☐ Short term or ☒ Long term

Monitoring measure 2.1	Monitor CHA's PCPCH weighted score.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
79% (weighted score)	85% (weighted score)	12/2023	89% (weighted score)	12/2024
Monitoring measure 2.2	Engagement with non-PCPCH clinics.			

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
0 monthly engagement meetings with non-PCPCH clinics	Monthly engagement meetings established with at least 1 of 3 non-PCPCH clinics	06/2023	At least 1 of 3 non-PCPCH clinics recognized as PCPCH	12/2023
Monitoring measure 2.3	**PCPCH Health Equity Data (REALD+SOGI)**			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Data reviewed ad-hoc	Create dashboards and reporting that can be available quarterly.	06/2023	Incorporate SOGI data into quarterly dashboards.	12/2023

A. **Project short title:** Cultural and Linguistic Services Provision

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project

If continued, insert unique project ID from OHA: 33

B. **Components addressed**

i. Component 1: CLAS standards
ii. Component 2 (if applicable): Health equity: Cultural responsiveness
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this is a CLAS standards project, which standard does it primarily address? 13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

In 2022, the domains CLAS Standards and Health Equity: Cultural Responsiveness were components for OHA Project #33, Cultural and Linguistic Services Provision (CLSP), a project continued for 2023. Since component requirements are very closely aligned for these domains, the following narrative supports both and is not separated by component. The Access: Cultural Considerations domain was included in this project in 2022; however, since OHA discontinued it as a TQS component for 2023 TQS, CHA will no longer report on current progress for this domain in TQS.

Cascade Health Alliance (CHA) and Klamath County continued to have similar challenges as many communities during 2021. The pandemic surge resulted in high service demand and a challenging labor market leading to many bandwidth constraints, affecting initiative timelines and limiting collaboration opportunities with community partners as both CHA

and many local organizations sought to fill roles associated with quality, equity, and delivery of services. While many organizations fought to stay afloat, quality improvement and transformation in some areas, particularly those associated with collaboration, hiring, and training and initiatives that may add extra responsibilities to a strained workforce, were put on hold. Additionally, the pandemic deepened health disparities and increased social needs.

Despite challenges, significant progress was made towards achieving CHA's health equity goals and placed CHA in a good position going into 2023. Throughout 2022, CHA continued to make great strides in expanding reporting capabilities of member demographics (healthy equity data), including interpreter needs and race, ethnicity, language, and disability (REALD). To help identify cultural and linguistic needs of members, CHA utilizes a monthly equity member demographics dashboard that includes REALD, age, gender, and marital status. The most recent member demographics dashboard is attached for reference. Previously, in recent years, CHA considered the member demographics dashboard to be its equity dashboard. Through the Closed-loop Grievance System (OHA Project #61) TQS project, CHA has activities that continuously work towards improving the capture, analysis, and use of data related to health equity priorities. CHA also has an activity in the Closed-loop Grievance System (OHA Project #61) TQS project to create and utilize an equity dashboard. The equity dashboard will include aggregated data related to member demographics, utilization, access, incentive metrics, and more. With the equity dashboard, CHA will be able to better identify improvement opportunities for initiatives. Once the equity dashboard is created, CHA will update information found in (CHA's Case Management platform), so member-facing staff have access to all member level data found in the equity dashboard. Limited equity data is currently found in the platform.

On August 29th, 2022, CHA moved its health equity department from the member services department to the quality department. The increasing alignment between health equity and quality efforts and deliverables guided CHA's decision. Then, on January 26th, 2023, CHA moved its quality and equity department to Operations, previously it was in medical management. These moves allowed CHA to more easily operationalize health equity while enhancing alignment for optimum performance and success.

With 1,151 (4.5%) Spanish speaking members as of December 14th, 2022, CHA began efforts to ensure all member materials are available in Spanish. Historically, most member materials were already available in Spanish. CHA's website has a button on the homepage that a user can click to translate the entire website into Spanish, this includes CHA's Provider Directory. If a provider speaks another language in addition to English, the language they speak is noted in CHA's Provider Directory. When CHA sends text messages for educational campaigns, any member who's preferred language is Spanish receives a text message in Spanish. Additionally, the member handbook is available in audio and large print formats. All other materials are available in large print upon request as they can be produced in-house quickly. Most member materials are not immediately available in audio format but are provided within 48 hours of the request.

CHA continued to its internal Health Equity Council (HEC) where representatives from multiple departments meet monthly and are tasked with improving social determinants of health and health equity (SDOH-E) and member experience for CHA members and the community at large. In conjunction with the Health Equity Plan (HEP), the HEC works towards establishing an innovative approach to increasing quality and equitable care delivered to the community through internal and external initiatives to eliminate health disparities, address CLAS standards, increase access to culturally and linguistically responsive services, educate staff about SDOH-E, analyze member demographic data, and provide a series of presentations by industry, regional, and tribal thought leaders. Three HEC subcommittees (Health Equity Operations, Training & Education, and Member Experience & Accessibility) continued to carry out the work of the HEC.

Furthermore, CHA partners with its provider network to ensure the provision of culturally and linguistically appropriate services to members by identifying areas of opportunity, gaps in services and community resources, and correct the consistent areas of member complaints. Additionally, CHA's annual provider audits verify clinics have a policy and

procedure for language line use and that they offer ADA accessibility as well as access to emergent, urgent, and after-hours care. If an issue develops that warrants action or a gap is identified, corrective action plans are developed along with strategies, target dates, deliverables, and additional monitoring programs to address any deficient services. Related to health equity, in 2022, CHA had zero grievances regarding "provider's office has a physical barrier/not ADA compliant, prevents access to office, lavatory, examination, room, etc."; however, one clinic had a grievance regarding "provider/plan bias barrier (age, race, religion, sexual orientation, mental/physical health, marital status, Medicare/Medicaid)". The grievance was from a member who felt they were not being treated with respect regarding dismissal from care. It was explained to the member that their complaint was not an issue of disrespect, but a general policy regarding missed appointments.

Additionally, CHA is one of the "Core Four" agencies that serve as the guiding force behind the Healthy Klamath partnership which is a coalition (Healthy Klamath Network) comprised of over 50 local Community Benefit Organizations (CBOs), health providers, and Klamath County Public Health who collaborate at every opportunity to improve the health of the community. In 2022, CHA and community partners continued to utilize FindHelp, a Community Information Exchange (CIE) platform dba Healthy Klamath Connect (HKC) and formally named Aunt Bertha. HKC functions as a central repository for the listing and availability of resources to provide local community services options for all community members (including CHA members) addressing SDOH needs. There are over 150 local community-based organizations offering services in Klamath County in the online platform offering over 200 programs for goods and services ranging from clothing, medical supplies, and food to care coordination, housing advice, temporary shelter, transit services, and advice related to housing, money, work, and legal needs. CHA staff have a specific user interface to assist with managing CHA members based on captured SDOH in HKC and (CHA's Case Management platform). HKC also functions as a social-needs referral platform to connect members to SDOH resources. Utilization of the platform for referral purposes is still limited; however, CHA continues to work with CHA staff and community partners to increase utilization of the platform as a search tool and referral platform. CHA also continued participation with our local Southern Oregon Health Information Exchange (HIE), Reliance eHealth Collaborative (Reliance eHealth). Reliance eHealth has some SDOH reporting which includes housing and food insecurities. CHA shares 837 data files with Reliance, and some other healthcare organizations share SDOH data from their electronic health records (EHRs).

To further identify and close social needs gaps, CHA has a multidisciplinary team focused on improving social determinates of health (SDOH) screening and referrals (through HKC) to improve identification of social needs to decrease health disparities for all members, including members who may not have received culturally and linguistically responsive services previously. This work is tracked through the Establish SDOH Screening and Referral Process performance improvement project (PIP) which is currently focused on infrastructure building for SDOH screening and referrals. Through the PIP, CHA is evaluating, testing, and updating current processes for social needs screening, data capture, data sharing, and closed-loop referrals. During the process to update CHA's internal infrastructure, CHA will collaborate with local organizations and providers who are already screening members to limit duplicative efforts, establish data-sharing protocols, and increase usage of HKC for referring members to resources. CHA also utilized Social Determinants of Health (SDOH) data from other sources to identify both member level and community level needs. These data sources include, but are not limited, to Health Risk Assessments (HRAs), Klamath County Community Health Assessment, and Well-Being data through BlueZones RealAge Test.

Cascade Health Alliance (CHA) leads and participates in multiple community engagement activities that advance CLAS Standards and the health equity plan (HEP). Some of these are described below.

- Community Advisory Council (CAC): CHA holds a monthly CAC meeting. Agenda topics include updates related to OHA, HEP progress, and collaboration with relevant community partners. For most of 2022, CAC meetings were held virtually, the annual retreat for 2022 was held in person though. Starting In November 2022, CAC started to have hybrid meetings every month.

- Healthy Klamath Network: Healthy Klamath Network is a proud partner with the sovereign Klamath Nation in addition to agencies and organizations in the seven sectors of community influence: media, government, education, economy, family, religion and arts, and entertainment. There are over 50 member organizations under the Healthy Klamath Network. Healthy Klamath was established to guide community health improvement efforts. As a member of the Healthy Klamath Steering Committee, CHA facilitates presentations at the bimonthly Healthy Klamath Network meetings. These presentations represent the progress on its CHIP priority taskforce and efforts to address health disparities in its service area. Meetings feature updates from the CHA/CHIP leadership and community partner presentations that support the vision of Healthy Klamath – a healthy community where ALL members have the ability to thrive and live a happy, healthy, and prosperous life.
- CHA/CHIP leadership: Through the Healthy Klamath Network, Klamath County has a shared Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) that is developed every three years. The foundational CHA/CHIP leadership in Klamath is comprised of the "Core Four" agencies: Cascade Health Alliance (the CCO), Klamath County Public Health, Klamath Health Partnership (the Federally Qualified Health Center), and Sky Lakes Medical Center (the hospital). During the monthly CHA/CHIP Leadership meeting, Cascade Health Alliance representative on the steering committee regularly provides updates regarding HEP progress. The Cascade Health Alliance representative facilitated listening sessions in multiple towns in Klamath County for the current cycle of the CHA/CHIP. The Klamath County Community Health Assessment 2021 was finalized on April 15, 2022. The Community Health Assessment was not finalized in 2021 due to delays related to COVID-19 and limited bandwidth from competing priorities caused by the pandemic.
- CHIP Workgroups: Multiple workgroups and subcommittees were created to allow teams to lead efforts of the focus areas selected for the 2022 CHIP. These focus areas are food insecurity, hunger; health promotion: access to services; mental health; physical activity; substance use; and equity. At least one CHA representative participates in each workgroup. A CHA representative even leads some of the efforts.
    - Workgroup Spotlight – Equity Workgroup: CHA co-leads the equity workgroup with the Health Equity Coordinator from Public Health. The equity workgroup has three subcommittees: resources, training, and events. The CHA representative leads the resources subcommittee and co-leads the training subcommittee.
- Hispanic Health Committee: One of the numerous subcommittees of the Healthy Klamath Coalition is the Hispanic Health Committee. The committee's overarching goal is to improve the health and wellbeing for the Hispanic population of Klamath county. The committee worked on establishing a Spanish-language streaming radio station throughout 2022. The radio station, La Voz de Klamath / The Voice of Klamath, will go live in 2023. CHA is an active participant in this committee.
- Klamath Promise: This is a "P20" education collaborative that brings together all levels of education, from Pre-K through graduate school (20), in collaborative service and civic activities to develop the skills, attitudes and understandings necessary for college, career, and civic readiness. As a member of the Executive Committee Klamath Promise Committee, CHA provides update on its efforts to advance health equity and partnership/funding opportunities relevant to the cause of the collaborative.
- Community Housing Plan Meeting: This meeting brings together multiple community partners from various sectors. The meeting's purpose is for planning, collaborating, leveraging funding, and increasing resources to support the need for safe, affordable, and efficient housing in Klamath County. Community partners include, but are not limited to, Klamath and Lake Community Action Services (KLCAS), Klamath Housing Authority (KHA), Klamath Tribes, Klamath Basin Behavioral Health (KBBH), Transformations Wellness Center (TWC), Klamath County Public Health, City of Klamath Falls, Sky Lakes

Care Management & Wellness, Red is the Road to Wellness (RRW), Klamath Works, Klamath County Economic Development Association (KCEDA), and Veterans Enrichment Center (VEC).

- Faith Based Core Group: A CHA representative regularly attends the local Faith Based Core Group. This group is full of local faith leaders who want to do their part in helping our community. Faith leaders lead efforts and make decisions. CHA and other Healthy Klamath Network members attend to offer support as needed.
- Community United Network Resources (CURN): This network was started with Community UpLift in late 2021. A representative from Health Families/UCAN facilitates monthly meetings. The purpose of the CURN meeting is to bring together representatives from local non-profit, faith-based, and community centered agencies to exchange information about their programs and better coordinate services to the community. The meeting features a presentation by an agency or community member. Following the presentation, participants are provided the opportunity to share information about their programs, services, and upcoming events. A CHA representative attends each month.
- Regional Outreach Coordinators of OHA facilitate Lake and Klamath County Collaborative. The collaborative holds monthly virtual meetings where CHA and EOCCO, the CCO in Lake County, provide relevant information about its care coordination and the work they do to address the social determinants of health and equity to the community-based organizations that participate in the collaborative.
- Systems of Care (SOC) Committee: SOC Committee meetings are held monthly. The SOC efforts address various focus areas of the HEP. The SOC also funds grants to Social Determinants of Health and Health Equity (SDOH-E) partners to provide services especially at hard-to-reach areas of Klamath. The SOC has workgroups that are external facing and that work on strategies and ideas for implementation to SOC:
    - Youth/family group – for youth and family members and be facilitated by youth leaders from Citizens for Safe Schools
    - Outreach/Engagement group – facilitate community outreach (both in general and for specific populations within our community) to increase youth and family participation in SOC governance. Additionally, this group works to engage with specific community populations who have been identified though the barrier submission process, as well as engagement strategies for community partners (existing and potential).
- Klamath and Lake Counties Area on Aging (KLCCOA) Advisory Council: A CHA representative sits on the advisory council of the local Area on Aging. This helps gives CHA insight into the happenings related to the older adult community. Additionally, KLCCOA has an Equity Plan. CHA aligns health equity efforts with KLCCOA as applicable.
- LGBTQ+ Activities: CHA had identified there are a couple local programs to support the LGBTQ+ community. Current efforts primarily support youth. CHA has not yet figured out how CHA will participate in efforts to support the LGBTQ+ population. Once CHA starts collecting SOGI data, CHA will have more insight into CHA's LGBTQ+ population and will have a better understanding of what CHA's role is at that time.
- CHA participates in community health and resource fairs, outreach events, and community vaccine clinics. At these events, CHA provides informational and educational materials to community members. Multiple of such events are held monthly in the Klamath service area.
- Additionally, CHA provides financial support to the community through the SHARE Initiative and Health Related Services (HRS). Both the SHARE and HRS funds support Community Benefit Initiatives that align with the HEP. The HRS Flex Funds support individual CHA members who face challenges in attaining their optimal health outcomes.

- COVID restrictions have reshaped community engagement in Klamath County as all collaborative meetings were held virtually for a while. Some meetings are beginning to allow in-person participation with a virtual option still included. Community outreach and events are also returning to pre-pandemic levels as well as being held in-person.

Please see the following attached as supporting documentation for this project:

- 2022 Member Demographics Dashboard
- Healthy Klamath Connect (HKC) Flyer
- HKC Training
- Establish SDOH Screening and Referral Process performance improvement project (PIP)

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

As demonstrated in section C, CHA made a lot of progress moving efforts forward related to health equity and CLAS. CHA especially made great strides on CLAS Standard 13: Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness. Some initiatives directly aligned with TQS activities. Other initiatives were more transformative and innovative than what CHA had initially planned. CHA opted to discontinue or modify some TQS activities due to shifting of priorities, workforce challenges, and/or TQS component changes. Additionally, through activities related to the Cultural and Linguistic Services Provision (CLSP) project, CHA continued to use the language line vendor implemented in 2021 which improved access and reporting related to interpretation needs. CLAS was a frequent topic in Health Equity Council (HEC) internal meetings as various subcommittees explored ways to improve implementation of all fifteen (15) CLAS standards.

2022 Monitoring Activity Updates for *Cultural and Linguistic Services Provision*:

- **Activity 1 (Achieve National Committee for Quality Assurance (NCQA) Distinction in Multicultural Health Care (MHC)):** NCQA transitioned Distinction in MHC into the Health Equity Accreditation with two tracks Health Equity Accreditation and Health Equity Accreditation Plus. CHA's long-term goal is to obtain the NCQA Health Equity Accreditation Plus. As noted in the component prior year assessment, there were challenges in advancing the work towards NCQA Distinction in MHC internally due to staffing challenges and externally due to pandemic-related capacity and coordination opportunities. With new Health Equity and Quality leadership staff in place, CHA will have a renewed focus on this goal in 2023. Due to these challenges, little progress toward reaching the project goals occurred in 2022; these goals included identifying two (2) to four (4) Patient-Centered Primary Care Home (PCPCH) partners to work with on the NCQA MHC Distinction, NCQA MHC Readiness Review with CAC, HEC, and PCPCH partners (Internal/External), NCQA MHC Gap Analysis with CAC, HEC, and PCPCH partners (Internal/External, and NCQA MHC Implementation Plan (Internal/External). The NCQA MHC goals will be continued in 2023 with an updated timeline.
- **Activity 2 (Meaningful Language Access):** CHA continues to work towards improving member language access, data collection, and reporting abilities. In the absence of bilingual providers or staff, CHA provides access to a language line for CHA staff, member, and provider use. CHA's ability to report on the utilization of language line is improving as CHA has contracted a new language line vendor who can now provide member-level data. However, some network providers do not use CHA's contracted language line, which limits CHA's ability to collect, aggregate, and analyze language access data for all member visits, and there is no systematic way to collect, aggregate and analyze data on the number of services provided by bilingual providers or their bilingual staff. With improved data processes, CHA will be able to more accurately analyze member-level language utilization data to guide the future identification of gaps, improvement opportunities, and solutions. During 2022, CHA focused on the Year 2 attestation objectives related to gathering member-level encounter data from providers. While ultimately successful in gathering additional information on services provided for this

population, CHA was unable to collect the desired volume of responses from the network with only 27% of eligible encounters being reported on (*Monitoring Measure 2.2 – Unsuccessful*). This encounter data was used to produce reports demonstrating current performance and these are shared with the provider network in metrics-focused meetings (*Monitoring Measure 2.1 – Success*). The focus for this year will be on achieving Year 3 requirements of the self-assessment for the MLA incentive measure tied to wait times reporting and increasing the volume of data received from providers around this work. Included in this focus will be the continued refining of our updated database and the production of improved language reports that include additional details around members who require interpreter services.

- **Activity 3 (Health Equity Workforce):** A new Health Equity Manager and a new Member Experience Program Coordinator (previously identified as Health Equity Coordinator) were hired in 2023. Additionally, CHA started the brainstorming phase of a more robust health equity training and education program, this program will include cultural competency training. Instead of focusing on hiring additional staff, CHA opted to focus efforts on training current staff. Educating the workforce will remain a focus for 2023. However, CHA will continue to seek and recruit employees that speak additional languages to ensure that services are culturally responsive to member needs and help transform the way that care is delivered.

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

The Cultural and Linguistic Services Provision (CLSP) project address two TQS components: CLAS Standards and Health Equity: Cultural Responsiveness. This is a multi-year project aiming to achieve several CLAS standards through internal activities as well as activities with our provider and community partners. While improving infrastructure, CHA will ensure members can participate in choosing services that are delivered in an appropriate setting and meet their unique needs. The primary CLAS standard addressed in this project is standard #13: Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

CLSP project activities will be supplemental to several focus areas outlined in Cascade Health Alliance's (CHA's) Health Equity plan and align with the activities of other TQS projects. In conjunction with the CLSP project, the Closed-loop Grievance System (OHA Project #61) TQS project supports the CLSP project through improving data capture and reporting (including race, ethnicity, language, and disability (REALD) data and sexual orientation and gender identity (SOGI) data), stratifying quality reports by REALD and SOGI, and the creation of the health equity dashboard and enhancement of the member profile in (CHA's case management platform). Through the Potentially Avoidable Costs in SPMI and THW Sustainable Capacity TQS project (OHA Project #59), CHA will continue to work with community partners to increase Traditional Healthcare Worker (THW) capacity to further assist and support members with accessing and navigating the health care delivery system, community and social support services and statewide resources. Through the Comprehensive PCPCH Plan TQS project (OHA Project #365), CHA will continue supporting provider partners in achieving patient-centered primary care homes (PCPCH) status or higher tier status if a clinic is already a recognized PCPCH. CHA will encourage non-PCPCH clinics to achieve PCPCH recognition as Meeting Language & Cultural Needs 6.A.0 (PCPCH offers time-of-service interpretation to communicate with patients, families, or caregivers in their language of choice) is a must-pass standard. Additionally, CHA will encourage lower-tier PCPCH to achieve 5 Star status and pick Meeting Language and Cultural Needs 6.A.1 (PCPCH provides written patient materials in non-English languages spoken by populations served at the clinic) as one of their 5 Star Designation Measures.

The first activity is focused on obtaining National Committee for Quality Assurance (NCQA) Health Equity Accreditation Plus, previously known as Distinction in Multicultural Health Care (MHC), by completing a readiness review, gap analysis, and creating an implementation plan using the NCQA guidelines as a gold standard while also reviewing and taking into consideration Oregon state and federal laws about accessibility and communication. Community participation will be implemented by involving the Community Advisory Council (CAC) in both the readiness review and gap analysis components of this activity as outlined in the Health Equity Plan. The activities for the CLAS standards portion of this TQS project will primarily focus on working with our provider and community partners and completing the same activities

with them that are being completed internally at CHA through the Health Equity Plan. However, while working through the NCQA Health Equity Accreditation Plus process, all fifteen (15) CLAS standards will be reviewed and addressed in the gap analyses and implementation plans to ensure CHA members and the Klamath community receive high quality care and services that are culturally and linguistically appropriate, address social determinants and health equity needs, and help to eliminate health care disparities for all. Upon implementation of all improvements, CHA will apply for the NCQA Health Equity Accreditation Plus which will complete this activity and demonstrate successfully meeting all CLAS standards.

NCQA Health Equity Accreditation requires an organization to align with six standards:

- HE 1: Organizational Readiness (includes building a diverse staff and promoting diversity, equity, and inclusion among staff)
- He 2: Race/Ethnicity, Language, Gender Identify, and Sexual Orientation Data
- HE 3: Access and Availability of Language Services
- HE 4: Practitioner Network Cultural Responsiveness
- HE 5 Culturally and Linguistically Appropriate Services Programs
- HE 6: Reduction of Health Care Disparities (including reporting stratified measures and using data for monitoring and assessing services)

The NCQA Health Equity Accreditation will demonstrate CHA's dedication to transformation as CHA will be a leader in CLAS standards in our community to ensure that all members have access to equitable care and services that are culturally and linguistically appropriate. The accreditation process will involve our provider network and community partners to ensure that not only our members, but the entire community has access to culturally and linguistically appropriate care and services. By achieving CLAS Standards throughout the CHA service area and Klamath County and successfully receiving the NCQA Health Equity Accreditation, it will help to eliminate health care disparities, ensure marginalized and vulnerable populations receive the care they need, improve member experience and satisfaction, improve quality of care and services, advance health equity, address social determinants of health, and improve health outcomes for individuals in our community.

The Meaningful Language Access (MLA) activity enables CHA to deliver culturally and linguistically appropriate services for members. This activity has two components designed to achieve this goal: (1) improved reporting on members' language interpretation needs, access to qualified interpreter services, and language line utilization with additional details in 2023 around wait times and costs for interpretation; and (2) develop and implement encounter-level interpreter-use reporting through provider electronic health record (EHR) systems and, in 2023, additional improvements in data gathering for wait time and interpretation cost data. For the first component, CHA has implemented internal reporting around language access needs and is sharing it with providers to ensure an equitable environment for all members. In 2023, this reporting will be enhanced with additional details around wait times and costs for interpreter services. The second component involves using the EHR reporting on language access that was developed in 2022 to gather wait time and interpreter costs data in 2023. This will allow CHA to gather and analyze additional information on language needs and help identify if there are disparities that affect utilization.

The Workforce Development activity continues to promote organization-wide cultural competence by further developing the new Health Equity staff positions and ensuring that all CHA staff are trained to recognize implicit biases and improve their cultural responsiveness. The Workforce Development activity intends to continue training CHA staff to improve their level of cultural competence, recognize implicit biases, and improve their cultural responsiveness to promote health equity. CHA will implement a monthly health equity training and education program for staff.

With CLAS standard 13 being the primary standard addressed with the CLSP project, planned activities as outlined above, address the following CLAS standards:

- 4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
- 5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
- 10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
- 11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
- 12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
- 15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the public.

F. **Activities and monitoring for performance improvement**:

Activity 1 description: Achieve National Committee for Quality Assurance (NCQA) Health Equity Accreditation Plus, previously known as Distinction in Multicultural Health Care (MHC), for CHA through readiness review, gap analysis, implementation plan, and final application. This process includes activities with external partners and PCPCH providers, and complements activities in the Health Equity plan and other TQS projects referenced in Section E (Project Narrative):

- Identify provider and community partner(s)
- Conduct readiness review with identified partners
- Conduct gap analysis with partners using the NCQA Health Equity Accreditation Plus guidelines as the gold standard for achieving CLAS standards and state and federal laws regarding communication and accessibility to exceed expectations for cultural responsiveness requirements
- Utilize CAC for readiness review and gap analysis process; leverage CAC for community education purposes and to support the CLSP project, activities within the project, and overall CLAS standards work
- Create implementation plan from gap analyses and readiness reviews
- Implement elements from the implementation plan with partners

☐ Short term or ☒ Long term

Monitoring measure 1.1	Partners identified, readiness review and gap analysis complete, and implementation plan(s) created			
Baseline or current state	**Target/future state**	**Baseline or current state**	**Target/future state**	**Baseline or current state**
1 PCPCH clinic at tier 5 (5 Star clinics have already implemented processes to achieve CLAS standards)	2-4 provider partners identified	06/2023	Partner readiness review and gap analysis completed	12/2023
Monitoring measure 1.2	Readiness review and gap analysis for NCQA Health Equity Accreditation Plus shared with CAC and HEC			

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No readiness review conducted	Readiness review completed and shared with CAC and HEC	09/2023	Gap analysis produced and shared with CAC and HEC	12/2023
Monitoring measure 1.3	New processes are implemented and sustained			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Gaps unknown	Gaps from gap analysis are closed and new processes are implemented	09/2024	New processes are sustained	12/2024
Monitoring measure 1.4	Achieve NCQA Health Equity Accreditation Plus, previously known as NCQA Distinction in Multicultural Healthcare (MHC)			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No implementation plan in place	Implementation plan created and in use as demonstrated by the initiation of NCQA Health Equity Accreditation Plus application process started	01/2025	NCQA Health Equity Accreditation Plus achieved	12/2025

Activity 2 description: Meaningful Language Access (MLA) Year 3 – Develop reporting to receive and share wait times and interpreter costs data with and from providers.

☒ Short term or ☐ Long term

Monitoring measure 2.1	Develop wait time and interpreter cost reporting (internal & shared with providers)			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No wait time and interpreter costs reports built	Internal reporting of wait time and interpreter costs is created and shared.	09/2023	Wait time and interpreter cost reporting shared with providers	12/2023
Monitoring measure 2.2	Develop Encounter-Level Reporting (received from provider EHRs)			

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No encounter-level reporting for wait times and interpreter cost from providers	CHA receives reporting from 40% of EHR-using providers	06/2023	CHA receives reporting from 100% of EHR-using providers	12/2024

Activity 3 description: Workforce Development – Implement a monthly health equity training and education program for staff

☐ Short term or ☒ Long term

Monitoring measure 3.1	**Develop and implement monthly health equity training program**			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Training occurs as needed annually	Program developed and implemented	06/2023	At least three trainings completed	12/2023
Monitoring measure 3.2	Monthly health equity trainings completed			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Training occurs as needed annually	Twelve trainings completed (one per month)	12/2024	Same as target	Same as target

A. **Project short title:** Holistic Diabetes Management (MEPP Episode: Diabetes)

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project

If continued, insert unique project ID from OHA: 366

B. **Components addressed**

i. Component 1: SHCN: Non-duals Medicaid
ii. Component 2 (if applicable): Utilization review
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this is a CLAS standards project, which standard does it primarily address? Choose an item
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☒ Yes ☐ No

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

In 2022, the domain SHCN: Non-duals Medicaid and Utilization Review were components for OHA Project #366, Holistic Diabetes Management (MEPP Episode: Diabetes), a project continued for 2023. While Access: Quality and Adequacy of Services was included in this project's scope in 2022, that component has been removed from TQS in 2023 and will not be reflected further in this assessment. Additional details on CHA's management of Access will be reported through DSN deliverables. In 2022, CHA opted to incorporate MEPP into TQS as part of alignment efforts, and activities in support of that alignment can be found in projects under the Utilization Review component.

SHCN: Non-duals Medicaid

CHA Case Management (CM) services are provided to members identified by risk, utilization, or referral through all sources for CM interventions. There are currently four CM programs in CHA's Care Management Model: Screening, High Risk/ Intensive Community Care Management (ICCM), Transitions of Care (TOC), and Short-Term Needs. CHA's CM department identifies members with Special Health Care Needs (SHCN) though screening and assessment. All new members to CHA, and those referred to case management through any source, complete a Health Risk Assessment (HRA)/ICCM screen. Utilizing the results of the screening, members are identified with SCHN. These results require a member to self-identify and the related case management chart is flagged to indicate the member's special need. Based on the screening, members are then evaluated to ensure that they have the proper resources and providers in place. If there is any gap discovered in services, the CM team works with the member and as needed, external providers, Utilization Review, and Provider Network teams to facilitate acquisition of services. If there is a repetitive gap in services, the Provider Network team is notified to improve network adequacy. Additionally, in the event of a poor outcome because of an access issue or lack of provider availability, CM will work with the member, the authorizations department, and provider network to mitigate barriers and increase availability of services within the CHA network.

Screening and resource provision is an ongoing activity for all members regardless of demographics or population characteristics, however, as CHA begins to develop reporting on disease prevalence, the ability to identify and take action on disparities will become an important factor in decision making in the future. While not immediately available, future reporting on conditions that fall under SHCN will also include available REALD and SOGI data to allow exploration of disparities found in priority populations with an emphasis on taking actions to reduce disparities wherever possible.

Utilization Review

CHA's utilization management program currently includes authorization and utilization review of medical, behavioral health, dental, and pharmacy services with review conducted by the Case Management and Pharmacy departments, with overall oversight by the Chief Medical Officer, the Utilization Review Committee (URC), and Pharmacy and Therapeutics (P&T) Committee. CHA completes monthly inter-rater reliability (IRR) for randomly selected medical, behavioral health, and dental authorizations. Findings of reliability below 85% are referred to the case management department for process improvement.

CHA utilization review (UR) staff spend most of their time processing and reviewing authorizations, appeals, and reconsiderations (provider appeals). CHA staff, P&R Dental, and URC members process appeals and reconsiderations (provider appeals).

Multiple reports are currently used to monitor utilization with some being produced regularly and others ad hoc. CHA consistently tracks utilization for certain services but does not currently have an integrated approach to monitoring utilization leading to an opportunity for more in-depth analysis and identification of improvement opportunities. CHA tracks utilization of high priority preventive services and percent of assigned members seen by primary care medical and

dental providers. CHA sets targets for these services and provides feedback to providers on a regular basis. CHA tracks a balanced measure set that includes over- and under-utilization, access measures, quality measures, medical complexity, and member complaints. All measures are reviewed monthly by the appropriate and responsible CHA departments, CHA leadership, and CHA's Quality Management Department to ensure medically appropriate, high-quality care is provided to CHA members. CHA provides monthly performance dashboards to providers which detail performance toward the incentive metrics targets by clinic, as well as risk scorecards which include ED and generic drug utilization. Additionally, CHA uses claims data monthly to track professional, primary care, behavioral health, inpatient, institutional, outpatient, dental, and pharmacy utilization and spending over time. CHA utilizes Optumas, through the Medicaid Efficiency and Performance Program (MEPP), and other tools to identify potentially avoidable cost (PAC) and adverse actionable events (AAE) for improvement opportunities. CHA's annual provider audits include a chart review to ensure services are accurately documented. Outside of TQS, CHA is building additional capacity and workflows to collect and monitor utilization using reports that are generated from claims on a monthly cadence. These reports will include primary care, specialty care, behavioral health, institutional, pharmacy and dental claims data with the ability to evaluate trends based on REALD and SOGI information, when available, to help identify and take action on disparities in utilization. In addition, CHA reviews utilization on a on a case-by-case basis for members identified as high utilizers.

Even with current policies and procedures, CHA continues to improve workflows and build capacity to more regularly produce all types of utilization monitoring needed to better identify improvement opportunities. Refer to attached Quality Assurance and Performance Improvement (QAPI) Policy and Procedure and Utilization Measures Review, Analyzation, and Remediation process for more information about how CHA detects under-utilization and over-utilization of services. Additional examples demonstrating CHA's methods to actively monitor utilization of services over time include, but are not limited to, the Peer Support Specialist (Figure 7) and SPMI/SUDs & Chronic Disease Cohorts (Diabetes, or CHF, or COPD, or Asthma) (Figure 6) dashboards found in Section D of OHA Project #59, Potentially Avoidable Costs in SPMI and THW Sustainable Capacity TQS project as well as the attached CHA Member Spend Year-Over-Year dashboards shared with URC and CHA leadership.

2022 Medicaid Efficiency & Performance Program (MEPP) Measures:

Independent MEPP projects were discontinued in 2021 as CHA adopted the December 2, 2021, guidance on efficiency and utilized Optumas data in support of other coordination care organization (CCO) work for two of the three MEPP projects in 2022. The third was wholly integrated into the TQS utilization review work for 2022.

The first MEPP data project is reflected in Activity 5 of the Holistic Diabetes Management project (OHA Project #366). This activity is intended to measure the effectiveness of the diabetic-focused interventions outlined in that project from an efficiency standpoint using Optumas data before and after the 2022 interventions. Additionally, Optumas data was to be used in identifying clinic outliers that could benefit from additional assistance in efficiency monitoring. Results of these two monitoring measures are reflected below:

OHA Project #366 - Activity 5 – MEPP Data Project – Reduction of Unnecessary Cost and Overspend for Members with a Diabetic Condition.

Monitoring Measure 5.1

Goal: Diabetic AAE reduction from 28% to 23% in measurement year 2023 data

Outcome: Target unlikely to succeed, revising goals

Notes: AAE data showed a 28% in 2020. The goal to reduce this to 23% by the end of 2023 assumed that cross-sector engagement on cost could be achieved and that member-level interventions would drive results. 2021 data was just released, and it showed a Diabetic AAE of 33%. Knowing that 33% is the new baseline, it is unlikely

that 2022 and 2023 preventative care efforts would have enough effect to reduce the measure by 10 basis points. Target outcome will not be confirmed until August of 2024. This measure will have targets revised to more reasonable levels of 30% Target for 2023 data and 27% Benchmark for 2025 data.

Monitoring Measure 5.2

Goal: Clinic AAE Outlier Engagement

Outcome: Measure retired

Notes: Clinic-level AAE data lacks the ability to evaluate behaviors necessary to change processes and workflows and makes a poor teaching tool. MEPP activity will continue to be a measure of intervention outcome in Monitoring Measure 5.1, but cost data will not be a primary factor in clinic discussions around quality transformation.

The second MEPP data project is reflected in Activity 4 of the Potentially Avoidable Costs in SPMI and THW Sustainable Capacity project (OHA Project #59). This activity was intended to serve as a collaboration element between primary care providers around costs associated with substance use disorder (SUD). The goal was to facilitate discussions between high-performing clinics and low-performing clinics and allow the sharing of best practices to drive improvement. As discussed above, regarding Diabetes Monitoring Measure 5.2, Optumas data is poorly suited for discussions around clinic behavior and this focus in Activity 4 is being retired. Many existing interventions are in place to help manage SUD among CHA members, and SPMI Monitoring Measure 4.1 will continue as a measurement of the effectiveness of all work collectively being done in this space, rather than as an outcome from cross-provider discussions:

OHA Project #59 – Activity 4 – MEPP Data Project – Reduction of Unnecessary Cost of Members with an SUD condition.

Monitoring Measure 4.1

Goal: Reduce SUD Episode AAE from 22% to 20% in 2022 and 16% in 2023.

Outcome: Target unlikely to succeed, revising Benchmark goal

Notes: AAE data showed a 22% in 2020. The goal to reduce this to 20% by the end of 2022 assumed that cross-sector engagement on cost could be achieved and that member-level interventions would drive results. 2021 data was just released, and it showed an SUD AAE of 25%. Knowing that 25% is the new baseline, it is unlikely that 2022 preventative care efforts would have enough effect to reduce the measure by 5 basis points. Target outcome will not be confirmed until August of 2023. This measure will have benchmark revised to a more reasonable level of 20% for 2023 data. If initial 2022 efforts can reduce unnecessary cost to closer to 2020 levels, sustaining those efforts in 2023 should yield a positive overall result.

The third MEPP project is an intervention in Activity 3 of the Potentially Avoidable Costs in SPMI and THW Sustainable Capacity project (OHA Project #59). This activity is intended to measure the effectiveness of interventions directed at SPMI populations as well as serve as a study of correlation between cost-reporting tools available to CHA. This correlation is being explored between the tool which measures Potentially Avoidable Costs (PACs) and the tool Optumas which measures Adverse-Actionable Events (AAEs).

OHA Project #59 – Activity 3 – MEPP Intervention Project – Reduction of Unnecessary Cost of Members with an SPMI condition.

Monitoring Measure 3.2

Goal: Reduce PAC of case managed members with SPMI & High ED use by 10% by October 2022.

Outcome: PAC reduction of 20.57% achieved

Notes: With a start-of-intervention PAC of 17.80% and an end-of-intervention PAC of 14.14%, the cohort saw a 3.66% improvement in PAC which is a 20.57% overall improvement against the baseline. While all factors that drive improvement can't be accounted for, this activity aimed to ensure that all cohort members were engaged in case management with CHA or local primary care groups.

Monitoring Measure 3.3

Goal: Record PAC of Schizophrenia sub-cohort members with SPMI & High ED use.

Outcome: Sub-Cohort PAC at end of intervention - 12.2%

Notes: This cohort had a starting PAC of 14.99% and an ending PAC of 12.2% showing a difference of 2.79% and an improvement on the baseline of 18.61% overall. This helps measure the intervention and provide a 2022 PAC value to compare with the AAE value that will be produced in August of 2023 for review. CHA will continue this set of correlative monitoring measures, across available SPMI sub-cohorts while this activity remains, in order to establish confidence in the two values.

Monitoring Measure 3.4

Goal: Record AAE of Schizophrenia sub-cohort members with SPMI & High ED use.

Outcome: TBD

Notes: Optumas data for 2022 will be available in August of 2023. At that time, this measure will be evaluated, and initial conclusions drawn around the relative similarity of both the and Optumas tools as methods to measure cost and overspend. The goal is to drive confidence in the methods found in and related suites of software which will allow the production of more real-time measurements of cost and allow faster pivoting for decision-makers when opportunities are presented.

Please see the following attached as supporting documentation for this project:

- Medication Therapy Management (MTM) Process [MTM plan]
- QAPI Plan PP09007
- Utilization Measures Review, Analyzation, and Remediation PP09007.01
- Provider Network Management Committee Charter
- Utilization Review Committee Charter
- Utilization Review Committee Agendas and Minutes
- CHA Member Spend Year-Over-Year

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

2022 – Project Justification Details

Per the International Journal of Preventative Medicine 2021, the holistic care approach to managing diabetes includes psychosocial, psychological support, lifestyle changes, health education, herbal food and medicine, culture, yoga, and technology (Juanamasta, I Gede et al. "Holistic Care Management of Diabetes Mellitus: An Integrative Review." *International journal of preventive medicine* vol. 12 69. 25 Jun. 2021, doi:10.4103/ijpvm.IJPVM_402_20). Cascade Health Alliance (CHA) acknowledged numerous diabetes focused initiatives were occurring in 2021 that collectively affected diabetes management holistically; however, these efforts were not well integrated. CHA evaluated the scope of these initiatives and opted to combine efforts where applicable and to align the initiatives and more efficiently use resources to improve results. As of November 2021, members with diabetes account for 6.5% (1,589 of 24,399 members) of CHA's overall member population.

Through Q1 and Q2 2021, CHA continued its Improving Diabetes Hemoglobin A1c (HbA1c) through Social Determinants of Health (SDOH) Screening and Community Information Exchange (CIE) Implementation performance improvement project (PIP). The project addressed members' social needs through screening and connection to needed resources and services. By doing so, members will have more margin in life capacity to better manage their diabetes and successfully lower their HbA1c. During Q3 2021, CHA realized it could not improve HbA1cs by screening and referring for social needs without first establishing infrastructure for social needs screening, data capture, and referrals to ensure outcomes are achieved. CHA abandoned the HbA1c through SDOH Screening and CIE PIP to move to an alternative PIP to solely focus on infrastructure building for SDOH screening and referrals. The diabetes work continued through a separate, internal Diabetes Workgroup. CHA plans to reconnect the diabetes and SDOH screening efforts once the SDOH screening and referring infrastructure is established and tested. Due to limited bandwidth in 2021, the multidisciplinary Diabetes Workgroup's progress was slow. CHA will utilize this workgroup to complete the work outlined within the Holistic Diabetes Management Program (OHA project #366) TQS project.

CHA has multiple ongoing tactics to help members manage their diabetes in addition to the initiatives already mentioned in Sections C and D of this project. Since the Public Health Emergency began in 2020, diabetic supplies are delivered to members. Previously, members picked up diabetic supplies at CHA and pharmacy technicians would ensure members knew how to use their supplies. This education piece ended once supplies needed to be delivered, and CHA is continuing to explore methods to supplement this education gap, including, but not limited, providing educational materials with diabetic supplies. CHA case managers also utilize Collective Medical to monitor hospitalizations to have a systematic way to check in on medical care and social needs with the member to help with disease management and care coordination. Additionally, CHA tested an opt-in text messaging program, Diabetic Care Compliance Program, in partnership with InOnHealth, previously known as access.mobile, as another tool to support disease management. The program educates and reminds participants of the importance of regular self-checks of blood sugars, medication adherence, a healthy dietary regimen, foot care, exercise, and general healthy lifestyle behaviors. The program currently has less than thirty (30) members signed up as it was difficult to get members to sign up through cold calls and the system is difficult to use and is time intensive to get users set up. Improvements are planned to make the system easier to use. CHA is an active member of the Healthy Klamath Expanded Network for Diabetes Management, a partnership designed to strengthen the existing rural health care network to improve diabetes-related outcomes among residents in Klamath County. This includes, but are not limited to, improving access to and utilization of diabetes prevention programs (DPP), establishing a DPP program that is culturally relevant (starting with a Spanish-speaking class), and utilizing FindHelp, a Community Information Exchange (CIE) platform dba Healthy Klamath Connect (HKC) and formally named Aunt Bertha, to improve the coordination of resources and better meet social needs to reduce health disparities.

Provider and other community partners work to improve diabetes management as well. Most members have diabetes managed through their primary care provider (PCP); however, an endocrinologist and a nurse practitioner who specializes in diabetes care are available locally. PCPs refer members newly diagnosed with diabetes to locally provided education about diabetes management to help them with the transition. In Q3 2021, Cascades East Family Medicine (CEFM) tried drive thru HbA1c testing but had little success. Klamath Health Partnership (KHP) dba Klamath Open Door (KOD), a Federally Qualified Health Center (FQHC), began piloting a diabetes distress screening tool in 2021; however, providers have completed limited screenings so far and impact on diabetes management is unknown at this time. Klamath Basin Behavioral Health (KBBH), one of the largest behavioral health clinics in Klamath County, started to train its clinical, non-prescribing staff, about how to help with diabetes management. Even though CHA and many organizations in Klamath County work to improve diabetes management, poor disease management and diabetes complication still exist and there appears to be, despite multiple organizations frequently working together, only partially coordinated efforts resulting in a perceived lack of education, support, and resources for members with diabetes. The cause of this perception will be further explored during 2022.

Utilization of services and health outcome measures are used to evaluate the success of diabetes management initiatives. They also identify key opportunities for interventions to improve overall health outcomes, specifically lowering their HbA1c. Specific measures related to the project's cohort are described in Section E and Section F, while this section focuses on the overall population of members with diabetes. According to Optumas, MEPP data, diabetic episodes contain approximately 28.0% of Potentially Avoidable Costs (PAC; adverse actionable event (AAE)) in 2020. This is down from 2018 and 2019 which was 29% in 2019 and 31% 2018. In comparison, CHA's overall PAC was 8% across all episodes of care in 2020. Once clinic-level provider attribution is updated in Optumas, CHA will be able to identify clinics with highest PAC/AAE and collaborate with them on improvement opportunities to reduce PAC/AAE. CHA will also identify the clinic with the lowest PAC/AAE to identify best practices. As of November 2021, for 1,589 members with diabetes, standalone ER visits/Observations had 61% PAC and accounted for 5.6% of total services, inpatient admissions had 36% PAC and accounted for 24% of total services, and skilled nursing admissions had 53% PAC and accounted for 0.5% of total services. Furthermore, diabetes continued to be the second most expensive drug category for the plan in 2021 despite efforts to manage the formulary and ongoing efforts to implement the MTM program. Based on CHA's predicted result for the 2021 Diabetes HbA1c Poor Control OHA Incentive Metric, 30.5% (365 of 1198 members) of adult members with diabetes had poor control of their diabetes during 2021. High HbA1c's can cause multiple complications resulting in worsened member health and higher PAC/AAE, so lowering HbA1cs continues to be a CHA focus area. Additionally, 17.5% (200 of 1141 members) of adult members with diabetes received an oral evaluation, per predicted results of the Oral Evaluation for Adults with Diabetes OHA Incentive Metric (Oral Eval measure). When considering adults members with diabetes who fall within the denominator of the Oral Eval measure, 61% (696 of 1150 members) received at least two HbA1c tests during 2021, 100% (1150 of 1150 members) are assigned to a primary care provider (PCP), and 91% (1051 of 1150 members) are assigned to a primary care dentist (PCD). Of note, patients with diabetes should have an HbA1c test completed every three to six months (at least twice a year), per the Centers for Disease Control and Prevention (CDC).

As described in Section C, CHA's MEPP activity is reflected in projects that include the Utilization Review category. Holistic Diabetes Management (OHA project #366) includes one (1) MEPP data project incorporating diabetes episodes while Potentially Avoidable Costs in SPMI and THW Sustainable Capacity (OHA project #59) contains one (1) intervention project (Behavioral Health (BH) Intervention Project) and one (1) data project (Substance Use Disorder (SUD) Data project) incorporating serious and persistent mental illness (SPMI) and substance use disorder (SUD) episodes, respectively.

2023 Continued Project Updates, Activities, & Outcomes

OHA Transformation and Quality Strategy (TQS) **CCO:** Cascade Health Alliance

As *Access* concerns are shifting away from TQS this year, to be addressed under DSN, the components of this project that were tied to *Access: Quality and Adequacy of Services* have been retired.

While individual activities and monitoring measures are noted below for their outcomes, root causes, and insights, an additional requirement for project review this year is the impact from REALD & SOGI data on decisions and project contexts. As this project focuses on the CHA diabetic population of approximately 1,350 of 26,000 members (~5%), we wanted to explore this population for any deviations that could indicate a health equity challenge or indicator of bias. In the CHA overall population, 15.92% of members self-identify as a minority race. In the diabetic population, this increases slightly to 16.37%, but is not a significant deviation considering the small populations being examined and the high variance possible in small groups. The close parallels are replicated even at the individual race and ethnicity levels as well. No one group appears to have a higher diabetic prevalence in the CHA population. When evaluating the outcomes of HbA1c measurements, we see a similar occurrence. With the CHA diabetic HbA1c average at 7.75, all race groups fall within a +/-0.5 range of that membership average.

Considering that our prevalence data does not indicate any biases or significantly disadvantaged populations, we have not changed the structure of activities and monitoring measures for this project in 2023.

New in 2023, CHA will develop a plan to collect sexual orientation and gender identity (SOGI) data during member onboarding and to stratify diabetic and other quality data by it once collected.

Holistic Diabetes Management Activities, Monitoring Measures & Outcomes:

Activity 1 – Holistic Data Capture & Reporting

1.1 – Identify and resolve data gaps found in environmental scan – **Target Met**. Activity is on track for Benchmark success by 12/2023

1.2 – Practical use of data by staff – **Target Met**. Activity is on track for Benchmark success by 12/2023.

Activity 2 – Update workflows as improved data is made available.

2.1 – Workflows updated & staff trained – **Target on track** for 06/2024 success once data gaps and staff usage are implemented. Benchmark on track for success by 12/2024.

Activity 3 – Community collaboration/Access to resources

3.1 – Member education resources – **Target revised**. Duplicating work between CHA-branded member education and Healthy Klamath-branded community education materials was unnecessary**.** On track for a Benchmark success by 06/2023.

3.2 – Provider-focused diabetes articles – **Target Not Met**. Caretalk publication went through restructuring in 2022 to accommodate provider needs and content visibility. As such, no diabetes articles were produced last year. As a bi-monthly production, a Benchmark of 4 diabetes articles per year is unreasonable, redefining the Benchmark goal at 3 per year. On track to attain Benchmark success by 12/2023.

3.3 – Engage provider groups to streamline diabetes care – **Target Met**. Care coordination and case management activities are very fluid and based on available resources. Being too prescriptive on process work sets under-resourced providers up for failure. *Monitoring measure 3.3 is being discontinued*.

3.4 – Healthy Klamath Connect Closed Loop Referrals – **On track for Target success** by 12/2023. Healthy Klamath Connect continues to be the best resource for service and referral activity in the area.

Activity 4 – Health Outcomes for Diabetic Members

4.1 – HbA1c Poor Control OHA incentive metric – **Target Met.** CHA achieved a 27.4% against a target of 30% (or less) in this measure. On track for Benchmark success by 12/2023.

4.2 – Oral Evaluations for Diabetic Persons OHA incentive metric – **Target Met**. CHA achieved an 18.9% against a target of 18% in this measure. On track for Benchmark success by 12/2023

4.3 – SDOH Screen & Referral Infrastructure – **Measure retired**. CHA continues to leverage community discussions around Healthy Klamath Connect to develop a robust referral platform that could serve the purposes of the SDOH OHA incentive metric. A measurement around SDOH referrals may be revisited in the future but is unnecessary for this activity at this time.

Activity 5 – MEPP Data Project – Reduction of Unnecessary Cost and Overspend

5.1 – Diabetic AAE reduction from 28% to 23% in measurement year 2023 data – **Target unlikely to succeed**. AAE data showed a 28% in 2020. The goal to reduce this to 23% by the end of 2023 assumed that cross-sector engagement on cost could be achieved and that member-level interventions would drive results. 2021 data was just released, and it showed a Diabetic AAE of 33%. Knowing that 33% is the new baseline, it is unlikely that 2022 and 2023 preventative care efforts would have enough effect to reduce the measure by 10 basis points. Target outcome will not be confirmed until August of 2024. This measure will have targets revised to more reasonable levels of 30% Target for 2023 data and 27% Benchmark for 2025 data.

5.2 – Clinic AAE Outlier Engagement – **Measure retired**. Clinic-level AAE data lacks the ability to evaluate behaviors necessary to change processes and workflows and makes a poor teaching tool. MEPP activity will continue to be a measure of intervention outcome, but cost data will not be a primary factor in clinic discussions around quality transformation.

Activity 6 – Diabetic Outreach Efforts

6.1 – Poor control members receive case management – **Target and Benchmark Not Met**. The goal was to engage diabetic members in poor control through our case management team to improve outcomes. With a target of engaging 25% of this initial roster (of 230 members) by June, and 50% by the end of the year, the final engaged population was only 8.02% (17 of 212 still active). This was due primarily to staffing churn in this department coupled with other high-priority tasks associated with member management. This measure will be repeated in 2023 to help establish a work process for diabetic management.

6.2 – Disengaged members receive HbA1c tests – **Target and Benchmark Met**. Of the 233 members on the initial roster for this measure that hadn't received an HbA1c test in 2021, 203 remained active throughout 2022. The remaining active members were recipients of various outreach attempts from the Member Services and Quality departments at CHA resulting in 104 of them getting HbA1c tests before the year was out (51.23% against a Benchmark of 50%). This was a successful measure that will be repeated in 2023 to develop a cadence of outreach for disengaged members.

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

By December 31, 2025, the Holistic Diabetes Management project aims to enhance current internal and systems-level infrastructure to cultivate alignment and active stakeholder engagement to establish a holistic, patient-centered diabetes management approach to guide care coordination and the development of treatment and care transitions and to improve health outcomes and health disparities while lowering the cost of diabetes management and reducing duplicative efforts. Stakeholders include CHA staff, members, provider partners, and community partners. This project intends to utilize currently available resources and includes or impacts, but are not limited to, coordination of care, access to health and social needs services, over- and under- utilization of services, potentially avoidable cost, adverse

actionable events, and OHA incentive metrics. This project will also utilize multiple Plan-Do-Study-Act (PDSA) cycles using small cohorts and is designed to be scalable. CHA will ensure members know how to utilize resources already available. If CHA discovers a valuable resource is unavailable, CHA will make every effort possible to make the resource available to members with diabetes.

Even though there is potential to affect all five key factors of realized access (availability, accessibility, accommodation, acceptability, and affordability), this project will most directly influence availability as CHA will ensure members with diabetes have access to quality and appropriate services (right care at the right time and place, using a patient-centered approach) to limit under-utilization of preventive care and treatment. CHA will continue to work closely with primary care in Klamath County. Through the Comprehensive PCPCH Plan TQS project (OHA Project #365), CHA will support our provider partners in achieving patient-centered primary care homes (PCPCH) status or higher tier status if a clinic is already a recognized PCPCH.

The Holistic Diabetes Management project (OHA project #366) will support CHA's utilization management program through the utilization of Optumas, and other data sources. Additional information about the utilization management program can be found in the Utilization Review prior year assessment in section C. MEPP data can be utilized in up to two projects as some other application of the MEPP data to support quality initiatives. For the Holistic Diabetes Management project (OHA project #366), CHA will utilize Optumas to monitor adverse actionable events (AAE) related to episodes of diabetes. Using Collective Medical, Transitions of Care processes, Healthy Klamath Connect (HKC), and other tools, processes, and resources, CHA staff will work with members to limit the number of emergency department (ED) and avoidable inpatient admissions.

While CHA enhances infrastructure, CHA will initially target three member groups through Activity 6. CHA Case Management staff will assist members with diabetes who are in poor control to help guide them to resources that will help manage their condition. These members will have a diabetic diagnosis and have a most recent 2022 A1c measure of 9 or greater. Additionally, CHA Case Management staff will engage diabetic members with high ED utilization to help establish preventative care through a primary care provider to help reduce ED use. Lastly, CHA Quality Management and/or Member Services staff will outreach to members with diabetes who do not have a recent HbA1c test to encourage them to get tests completed in a timely manner. These members will have a diabetic diagnosis and have no A1c measurements on record from 2022. Since Activity 6 can be completed with resources CHA currently has in place, CHA will conduct this activity while completing additional infrastructure enhancements for the remainder of the project. Member engagement will be tracked in Activity 6 overall, and a reduction in ED use among high-ED utilizers will be tracked in measured outcomes in Monitoring Measure 4.3.

If CHA has continued success with diabetes efforts, CHA will consider expanding the project to include pre-diabetes and explore using similar methodology for other chronic diseases with the goal of transitioning this approach from transformational to routine as the project is retired.

F. Activities and monitoring for performance improvement:

Activity 1 description: Enhance built system to enable holistic data capture and reporting on members with diabetes in alignment with broader efforts to quantify disease prevalence across the entire member population. This will guide efforts in targeting specific health outcomes and develop interventions to improve outcomes.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Identify and solve information gaps to enhance holistic data capture and reporting

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Environmental scan of current data completed	Gaps identified in environmental scan are resolved	12/2023	Gaps identified in environmental scan are resolved	12/2023
Monitoring measure 1.2	Increase accessibility to data for practical use by member facing staff			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Data needs of member facing staff have been identified.	Methods implemented to ensure necessary data is readily accessible to member facing staff	12/2023	Methods implemented to ensure necessary data is readily accessible to member facing staff	12/2023

Activity 2 description: As the Holistic Diabetes Management project progresses, update and document workflows based on data availability, standardized processes, and best practices to enhance member engagement and improve health outcomes.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Workflows are updated, staff are trained, and enhanced processes are implemented			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Workflows are based on current processes	Updated workflows are documented as processes are enhanced	06/2024	Applicable staff are trained on updated workflows for implementation of enhanced processes	12/2024

Activity 3 description: Collaborate with community partners to enhance interorganizational collaboration and systems-level infrastructure to improve knowledge of diabetes management and improve access to available resources.

☐ Short term or ☒ Long term

Monitoring measure 3.1	Member education resources			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Limited resources available	Healthy Klamath branded guideline-based materials	06/2023	Healthy Klamath branded guideline-based materials	06/2023

	targeted at all community members		targeted at all community members	
Monitoring measure 3.2	Diabetes articles directed at providers			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Care Talk (provider newsletter) articles about diabetes are not regularly scheduled	3 diabetes focused Care Talk articles per year	12/2023	3 diabetes focused Care Talk articles per year	12/2023
Monitoring measure 3.4	Utilize Healthy Klamath Connect, local Community Information Exchange (CIE), for closed loop referrals to SDOH-E resources			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
In 202s, 52% (86 of 165) of Healthy Klamath Connect referrals were closed loop referrals	75% of Healthy Klamath Connect referrals are closed loop referrals	12/2023	90% of Healthy Klamath Connect referrals are closed loop referrals	12/2024

Activity 4 description: Monitor the effects of the Holistic Diabetes Management project on health outcomes, access to services (under-utilization), and health disparities for members with diabetes

☐ Short term or ☒ Long term

Monitoring measure 4.1	Diabetes HbA1c Poor Control OHA Incentive Metric			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
27.4% of adult members with diabetes had poor control of their A1c during 2022	28.5% of adult members with diabetes have poor control of their A1c	12/2023	28.5% of adult members with diabetes have poor control of their A1c	12/2023
Monitoring measure 4.2	Oral Evaluation for Adults with Diabetes OHA Incentive Metric			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
18.9% of adult members with diabetes received an oral evaluation in 2022	19% of adult members with diabetes received an oral evaluation	12/2023	19% of adult members with diabetes received an oral evaluation	12/2023

Monitoring measure 4.3	Reduce 12-month average # of ER visits among Diabetic members with high ER utilization (Data source,			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Diabetic members classified as high ER utilizers average 9.92 visits per member in March of 2023	Reduce average ER visits by 5% to 9.42 among initial cohort of high ER utilizers	9/2023	Reduce average ER visits by 10% to 8.42 among initial cohort of high ER utilizers	12/2023

Activity 5 description, MEPP Data Project: Using Optumas (MEPP) data, monitor the reduction of over utilization and avoidable use of health services related to adverse actionable events (AAE) for members with diabetes as a potential impact of the Holistic Diabetes Management project

☐ Short term or ☒ Long term

Monitoring measure 5.1	**MEPP Data Measure** – Adverse actionable events (AAE) of diabetic episodes (Data source: Optumas)			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Diabetic episodes contain approximately 33.0% AAE in 2021	Diabetic episodes contain approximately 30% AAE	12/2023 (data available August 2024)	Diabetic episodes contain approximately 27% AAE	12/2025

Activity 6 description: For members with a diabetic diagnosis, use a two-pronged approach of outreach to have untested members get A1c tests and increase Case Management of members with diabetes who are in poor control.

☐ Short term or ☒ Long term

Monitoring measure 6.1	CHA Case Management outreach to members with diabetes in Poor Control.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
8% (16/208) of adult members with diabetes who have A1c's 9 or higher at the end of 2022 received CHA case management	25% of adult members with diabetes who have A1c's 9 or higher receive CHA case management	06/2023	40% of adult members with diabetes who have A1c's 9 or higher receive CHA case management	12/2023

Monitoring measure 6.2	Increase A1c screening for members with diabetes with No Recent A1c Test through Provider and/or CHA outreach to all members without an A1c test in 2022.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
462 adult members with diabetes did not receive an A1c test in 2022	25% of adult members with diabetes who did not receive an A1c test in 2022 are tested	06/2023	50% of adult members with diabetes who did not receive an A1c test in 2022 are tested	12/2023
Monitoring measure 6.3	Engage Diabetic Members with high ER utilization in case management activity			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
65 adult members with diabetes and high Ed utilization identified	25% cohort engaged in case management	06/2023	50% of cohort engaged in case management	12/2023

A. **Project short title:** Potentially Avoidable Costs in SPMI and THW Sustainable Capacity (MEPP Episodes: Schizophrenia and SUD)

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project

If continued, insert unique project ID from OHA: 59

B. **Components addressed**

i. Component 1: Behavioral health integration
ii. Component 2 (if applicable): Serious and persistent mental illness
iii. Component 3 (if applicable): Utilization review
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this is a CLAS standards project, which standard does it primarily address? Choose an item
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☒ Yes ☐ No

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

In 2022, the components of Behavioral Health Integration and Serious and Persistent Mental Illness and Utilization Review were components of OHA Project #59, Potentially Avoidable Costs in SPMI and THW Sustainable Capacity, a project that is continuing in 2023.

Behavioral Health Integration & Serious and Persistent Mental Illness

CHA and community partners continued to utilize FindHelp, a Community Information Exchange (CIE) platform dba Healthy Klamath Connect (HKC) and formally named Aunt Bertha. HKC functions as a central repository for the listing and availability of resources to provide local community services options for all community members (including CHA members) addressing SDOH and care coordination needs. There are over 150 local community-based organizations offering services in Klamath County in the online platform offering over 200 programs for goods and services ranging from clothing, medical supplies, and food to housing advice, temporary shelter, transit services, and advice related to housing, money, work, and legal needs. HKC can be used as a closed-loop referral system when programs have been claimed by the community-based organizations that run them. When a community-based organization claims their program, they gain access to a user interface that allows their staff to manage the referrals they receive and the referrals they send to other programs on behalf of their clients. CHA staff have a specific user interface to assist with managing CHA members based on captured SDOH needs in HKC and (CHA's case management platform). CHA staff utilize HKC to track closed-loop referrals to ensure members receive the services for which they were referred. Outside of referrals to programs, HKC also functions as a social-needs platform to connect members to SDOH resources such as clothing or food. CHA and community partners also continued participation with the local Southern Oregon Health Information Exchange (HIE), Reliance eHealth Collaborative, which enables a variety of information sharing, notification, and referral actions for further integration of care. Klamath Basin Behavioral Health (KBBH) utilizes Reliance for referrals from primary care as well as to review pertinent information within the Community Health Record for their patients.

A key community partner in treating alcohol and other drug (AOD) disorders, Transformations Wellness Center (TWC), obtained a SAMHSA grant in early 2020 with the aim to decrease emergency department (ED) utilization using Peer Recovery Support Specialists (PRSS). PRSS' have expanded training in addition to the core Peer Support Specialist curriculum. This opportunity added four (4) THW staff to their clinic. The grant supports peers working directly with patients who present to the emergency department (ED) with an AOD related condition. The originally planned workflow was for the ED to notify TWC who then dispatches a PRSS to the ED. The PRSS would make face to face contact with the member to initiate the support process and encourages assessment and treatment if appropriate. Support also includes introduction to 12-step programs and other community resources identified to reduce the harm associated with AOD use/abuse. However, due to COVID-19 restrictions, this work was halted for 2020 year and most of 2021. Towards the end of 2021, TWC had meetings with the ED to try and find alternate options to engage the PRSS' with patients presenting to the ED with an AOD related condition. TWC PRSS' have been eager to resume collaboration with the ED to provide this needed service to the community once pandemic workplace restrictions allowed, and that opportunity came in 2022. Currently, the ED has access to a TWC PRSS to support AOD patients as needed.

Another area where CHA supports integration is through work being done towards improving the Initiation & Engagement in Treatment of Alcohol and Other Drug (IET) OHA incentive metric as part of CHA's Performance Improvement Project (PIP) work. CHA hosts a monthly collaborative discussion around the needs of substance use disorder (SUD) patients and expectations for treatment and support. Attendees of this collaborative include representatives of both BH and primary care facilities with the aim of reducing barriers to access, speeding up referral times, and improving the overall effectiveness of SUD treatment.

Additional community involvement continues in furtherance of BH integration. Klamath Basin Behavioral Health (KBBH) and Sky Lakes Medical Center (SLMC) have maintained The Link Access Center, a collaborative BH and sobering center in Klamath Falls. The Link Access Center offers walk-in behavioral health services daily and voluntary sobering services 24 hours a day, seven days a week. The Link Access Center provides a service entry point for individuals experiencing mental health and addiction challenges and is designed to remove barriers to engaging in local BH services.

Collaboration at the new facility also includes staffing and operations support from The Klamath Tribes to ensure culturally responsive and best practice services for the Tribal community.

Additionally, Klamath Health Partnership (KHP) dba Klamath Open Door (KOD), a Federally Qualified Health Center (FQHC), continued functioning as a fully integrated clinic offering physical, oral, and behavioral health services at one location. For patients with greater BH needs, KHP has a primary care provider co-located at Klamath Basin Behavioral Health (KBBH, Community Mental Health Program (CMHP)) who can assess for physical and oral health needs and refer patients to Klamath Open Door's main clinic for treatment if needed. Also, when a primary care provider identifies a BH need with a patient during a visit, the provider will assist the patient to schedule an appointment with BH before they leave the clinic. KHP continues to be an example of best practice as integration work continues.

All of these integration efforts in the county are intended to promote the efficient use of behavioral health resources that can be scarce in a rural region. CHA continues to work with local partners to ensure additional training for traditional health workers (THWs) that serve the community. THWs can help identify patients in need of specific services and ensure their proper referral, or they can serve as an early intervention to mitigate issues that could increase in severity over time. By promoting additional training of THWs, CHA aims to match each member need with a qualified resource. When combined with integrated referral systems like HKC, and active monitoring of patient segments as shown in Activity 3 of this project, CHA behavioral health staff is improving care by taking the initiative and being proactive with available services.

Utilization Review

CHA's utilization management program currently includes authorization and utilization review of medical, behavioral health, dental, and pharmacy services with review conducted by the Case Management and Pharmacy departments, with overall oversight by the Chief Medical Officer, the Utilization Review Committee (URC), and Pharmacy and Therapeutics (P&T) Committee. CHA completes monthly inter-rater reliability (IRR) for randomly selected medical, behavioral health, and dental authorizations. Findings of reliability below 85% are referred to the case management department for process improvement.

CHA utilization review (UR) staff spend most of their time processing and reviewing authorizations, appeals, and reconsiderations (provider appeals). CHA staff, P&R Dental, and URC members process appeals and reconsiderations (provider appeals).

Multiple reports are currently used to monitor utilization with some being produced regularly and others ad hoc. CHA consistently tracks utilization for certain services but does not currently have an integrated approach to monitoring utilization leading to an opportunity for more in-depth analysis and identification of improvement opportunities. CHA tracks utilization of high priority preventive services and percent of assigned members seen by primary care medical and dental providers. CHA sets targets for these services and provides feedback to providers on a regular basis. CHA tracks a balanced measure set that includes over- and under-utilization, access measures, quality measures, medical complexity, and member complaints. All measures are reviewed monthly by the appropriate and responsible CHA departments, CHA leadership, and CHA's Quality Management Department to ensure medically appropriate, high-quality care is provided to CHA members. CHA provides monthly performance dashboards to providers which detail performance toward the incentive metrics targets by clinic, as well as risk scorecards which include ED and generic drug utilization. Additionally, CHA uses claims data monthly to track professional, primary care, behavioral health, inpatient, institutional, outpatient, dental, and pharmacy utilization and spending over time. CHA utilizes Optumas, through the Medicaid Efficiency and Performance Program (MEPP), and other tools to identify potentially avoidable cost (PAC) and adverse actionable events (AAE) for improvement opportunities. CHA's annual provider audits include a chart review to ensure services are accurately documented. Outside of TQS, CHA is building additional capacity and workflows to collect and monitor utilization using reports that are generated from claims on a monthly cadence. These reports will include primary care,

specialty care, behavioral health, institutional, pharmacy and dental claims data with the ability to evaluate trends based on REALD and SOGI information, when available, to help identify and take action on disparities in utilization. In addition, CHA reviews utilization on a on a case-by-case basis for members identified as high utilizers.

Even with current policies and procedures, CHA continues to improve workflows and build capacity to more regularly produce all types of utilization monitoring needed to better identify improvement opportunities. Refer to attached Quality Assurance and Performance Improvement (QAPI) Policy and Procedure and Utilization Measures Review, Analyzation, and Remediation process for more information about how CHA detects under-utilization and over-utilization of services. Additional examples demonstrating CHA's methods to actively monitor utilization of services over time include, but are not limited to, the Peer Support Specialist (Figure 7) and SPMI/SUDs & Chronic Disease Cohorts (Diabetes, or CHF, or COPD, or Asthma) (Figure 6) dashboards found in Section D of OHA Project #59, Potentially Avoidable Costs in SPMI and THW Sustainable Capacity TQS project as well as the attached CHA Member Spend Year-Over-Year dashboards shared with URC and CHA leadership.

2022 Medicaid Efficiency & Performance Program (MEPP) Measures:

Independent MEPP projects were discontinued in 2021 as CHA adopted the December 2, 2021, guidance on efficiency and utilized Optumas data in support of other coordination care organization (CCO) work for two of the three MEPP projects in 2022. The third was wholly integrated into the TQS utilization review work for 2022.

The first MEPP data project is reflected in Activity 5 of the Holistic Diabetes Management project (OHA Project #366). This activity is intended to measure the effectiveness of the diabetic-focused interventions outlined in that project from an efficiency standpoint using Optumas data before and after the 2022 interventions. Additionally, Optumas data was to be used in identifying clinic outliers that could benefit from additional assistance in efficiency monitoring. Results of these two monitoring measures are reflected below:

OHA Project #366 - Activity 5 – MEPP Data Project – Reduction of Unnecessary Cost and Overspend for Members with a Diabetic Condition.

Monitoring Measure 5.1

Goal: Diabetic AAE reduction from 28% to 23% in measurement year 2023 data

Outcome: **Target unlikely to succeed, revising goals**

Notes: AAE data showed a 28% in 2020. The goal to reduce this to 23% by the end of 2023 assumed that cross-sector engagement on cost could be achieved and that member-level interventions would drive results. 2021 data was just released, and it showed a Diabetic AAE of 33%. Knowing that 33% is the new baseline, it is unlikely that 2022 and 2023 preventative care efforts would have enough effect to reduce the measure by 10 basis points. Target outcome will not be confirmed until August of 2024. This measure will have targets revised to more reasonable levels of 30% Target for 2023 data and 27% Benchmark for 2025 data.

Monitoring Measure 5.2

Goal: Clinic AAE Outlier Engagement

Outcome: **Measure retired**

Notes: Clinic-level AAE data lacks the ability to evaluate behaviors necessary to change processes and workflows and makes a poor teaching tool. MEPP activity will continue to be a measure of intervention outcome in Monitoring Measure 5.1, but cost data will not be a primary factor in clinic discussions around quality transformation.

The second MEPP data project is reflected in Activity 4 of the Potentially Avoidable Costs in SPMI and THW Sustainable Capacity project (OHA Project #59). This activity was intended to serve as a collaboration element between primary care providers around costs associated with substance use disorder (SUD). The goal was to facilitate discussions between high-performing clinics and low-performing clinics and allow the sharing of best practices to drive improvement. As discussed above, regarding Diabetes Monitoring Measure 5.2, Optumas data is poorly suited for discussions around clinic behavior and this focus in Activity 4 is being retired. Many existing interventions are in place to help manage SUD among CHA members, and SPMI Monitoring Measure 4.1 will continue as a measurement of the effectiveness of all work collectively being done in this space, rather than as an outcome from cross-provider discussions:

OHA Project #59 – Activity 4 – MEPP Data Project – Reduction of Unnecessary Cost of Members with an SUD condition.

Monitoring Measure 4.1

Goal: Reduce SUD Episode AAE from 22% to 20% in 2022 and 16% in 2023.

Outcome: **Target unlikely to succeed, revising Benchmark goal**

Notes: AAE data showed a 22% in 2020. The goal to reduce this to 20% by the end of 2022 was based on the assumption that cross-sector engagement on cost could be achieved and that member-level interventions would drive results. 2021 data was just released, and it showed an SUD AAE of 25%. Knowing that 25% is the new baseline, it is unlikely that 2022 preventative care efforts would have enough effect to reduce the measure by 5 basis points. Target outcome will not be confirmed until August of 2023. This measure will have benchmark revised to a more reasonable level of 20% for 2023 data. If initial 2022 efforts can reduce unnecessary cost to closer to 2020 levels, sustaining those efforts in 2023 should yield a positive overall result.

The third MEPP project is an intervention in Activity 3 of the Potentially Avoidable Costs in SPMI and THW Sustainable Capacity project (OHA Project #59). This activity is intended to measure the effectiveness of interventions directed at SPMI populations as well as serve as a study of correlation between cost-reporting tools available to CHA. This correlation is being explored between the tool which measures Potentially Avoidable Costs (PACs) and the tool Optumas which measures Adverse-Actionable Events (AAEs).

OHA Project #59 – Activity 3 – MEPP Intervention Project – Reduction of Unnecessary Cost of Members with an SPMI condition.

Monitoring Measure 3.2

Goal: Reduce PAC of case managed members with SPMI & High ED use by 10% by October 2022.

Outcome: **PAC reduction of 20.57% achieved**

Notes: With a start-of-intervention PAC of 17.80% and an end-of-intervention PAC of 14.14%, the cohort saw a 3.66% improvement in PAC which is a 20.57% overall improvement against the baseline. While all factors that drive improvement can't be accounted for, this activity aimed to ensure that all cohort members were engaged in case management with CHA or local primary care groups.

Monitoring Measure 3.3

Goal: Record PAC of Schizophrenia sub-cohort members with SPMI & High ED use.

Outcome: **Sub-Cohort PAC at end of intervention - 12.2%**

Notes: This cohort had a starting PAC of 14.99% and an ending PAC of 12.2% showing a difference of 2.79% and an improvement on the baseline of 18.61% overall. This helps measure the intervention and provide a 2022 PAC value to compare with the AAE value that will be produced in August of 2023 for review. CHA will continue this set of correlative monitoring measures, across available SPMI sub-cohorts while this activity remains, in order to establish confidence in the two values.

Monitoring Measure 3.4

Goal: Record AAE of Schizophrenia sub-cohort members with SPMI & High ED use.

Outcome: **TBD**

Notes: Optumas data for 2022 will be available in August of 2023. At that time, this measure will be evaluated, and initial conclusions drawn around the relative similarity of both the and Optumas tools as methods to measure cost and overspend. The goal is to drive confidence in the methods found in and related suites of software which will allow the production of more real-time measurements of cost and allow faster pivoting for decision-makers when opportunities are presented.

Please see the following attached as supporting documentation for this project:

- QAPI Plan PP09007
- Utilization Measures Review, Analyzation, and Remediation PP09007.01
- Utilization Review Committee Charter
- Utilization Review Committee Agendas and Minutes
- CHA Member Spend Year-Over-Year

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

2022 Project Context (Revised in 2021 to include UR)

This project's work began as part of CHA's ED Utilization Performance Improvement Project (PIP) in 2018 when data demonstrated the need to manage high utilizers among the severe and persistent mental illness (SPMI) population as well as those presenting to the ED with an AOD related condition. Also developed along-side the ED PIP was an interdisciplinary care coordination team meeting held at two different Patient-Centered Primary Care Homes (PCPCH) clinics with primary care providers, behavioral health (BH) providers, CHA's BH care coordinator, a representative from CHA's Case Management department, representatives from other case management services within the community, and other service providers as needed to address individual patient care needs including, but not limit to, prevention, treatment, maintenance, recovery, and social needs. In Q1 2020, the PIP was closed, and work transitioned to the Initiation and Engagement in Treatment Performance Improvement Project (PIP) and the Behavioral Health Providers monthly meeting. The focus of the work also shifted to supporting BH providers in building the community's Traditional Health Worker (THW) capacity so peers can work directly with this specific population. While building the local THW capacity, CHA Case Management also continues to work with the SPMI community through targeted interventions aimed at reducing cost and ED utilization. The Potentially Avoidable Costs in SPMI and THW Sustainable Capacity (OHA Project #59) project aligns with the work accomplished within CHA's Case Management department to meet the increased BH and case management contract requirement of CCO2.0. During 2022, CHA will continue to build on that work as CHA refines its processes to better identify and track its most vulnerable members and implement, measure, and evaluate interventions.

In addition to building capacity of THW work, CHA continues to work to improve referrals to and utilization of social needs resources (social determinants of health, SDOH). Discussed above and in other projects, HKC is used to connect community members to needed services provided by local Community Benefit Organizations. HKC makes it easy for providers who identify members with social needs to find resources and make referrals to appropriate programs and services such as food, shelter, health care, employment, financial assistance, and more. The platform includes a closed feedback loop to track referrals and receipt of services.

MEPP Projects

As described in Section C, CHA's MEPP and TQS efforts were aligned closely, so CHA opted to combine MEPP and TQS reporting for 2022. Holistic Diabetes Management (OHA project #366) includes one (1) MEPP data project incorporating diabetes episodes while Potentially Avoidable Costs in SPMI and THW Sustainable Capacity (OHA project #59) contains one (1) intervention project (Behavioral Health (BH) Intervention Project) and one (1) data project (substance use disorder (SUD) Data project) incorporating serious and persistent mental illness (SPMI) and substance use disorder (SUD) episodes respectively.

2023 Continued Project Updates, Activities, & Outcomes

In 2022, CHA continued utilizing its Behavioral Health staff to engage members with SPMI to improve care through enrollment in case management services. Additionally, community partners were utilized and empowered to continue the growth of our local THW workforce through training and deployment activities. Outcomes from this work can be seen in the details below.

SPMI & THW Activities, Monitoring Measures & Outcomes:

Activity 1 – Increase community capacity of THWs

1.1 – Complete training for at least 20 new THWs – **Target & Benchmark Met**. In 2022, the Klamath County community added 20 new THWs. Increased utilization of Peer Support Services in 2022 is shown in *Figure 7*, demonstrating the continued demand for additional THWs in the community.

Activity 2 – Select cohort and develop targeted care plans for these members

2.1 – Establish care plans for at least 50% of cohort members – **Target and Benchmark Met.** 72% of cohort members were engaged in case management activity during the activity.

Activity 3 – MEPP Intervention Project – Monitor cohort in Activity 2 for changes in PAC and other metrics

3.1 – Establish reporting platform and analysis cadence – **Target and Benchmark Met**. Methods for gathering and reporting on activity within this cohort were effective (see Figure 6).

3.2 – Reduce cohort PAC by 10% – **Target & Benchmark Met**. PAC reduced by 20.57% during this intervention.

3.3 – Record change in PAC of Schizophrenia sub-cohort – **Target & Benchmark Met**. PAC of sub-cohort reduced by 18.61% during this intervention.

3.4 – Record change in AAE of Schizophrenia sub-cohort – **Ongoing**. AAE data at start of intervention recorded at 9.29%. AAE data at end of intervention will be available in Optumas 2022 data when it is released around August of 2023. Change in AAE will be reviewed and compared with the results in measure 3.3 to evaluate correlation and establish confidence in real-time PAC predictions from the software platform.

Activity 4 – MEPP Data Project – Reduce AAE of members with SUD

4.1 – Reduce SUD AAE to 16% by the end of 2023 – **Target unlikely to succeed, revising Benchmark**. SUD AAE data showed a 22% in 2020. The goal to reduce this to 20% by the end of 2022 and 16% by the end of 2023 assumed

that cross-sector engagement on cost could be achieved and that member-level interventions would drive results. 2021 data was just released, and it showed an SUD AAE of 25%. Knowing that 25% is the new baseline, it is unlikely that 2022 preventative care efforts would have enough effect to reduce the measure by 5 basis points. Target outcome will not be confirmed until August of 2023. This measure will have benchmark revised to a more reasonable level of 20% for 2023 data. If initial 2022 efforts can reduce unnecessary cost to closer to 2020 levels, sustaining those efforts in 2023 should yield a positive overall result. Benchmark data will be available around August of 2024.

Figure 6

Outcomes for Activities 2 & 3 - Potentially Avoidable Costs in SPMI and THW Sustainable Capacity

SPMI with High ED Use - 2022 Cohort

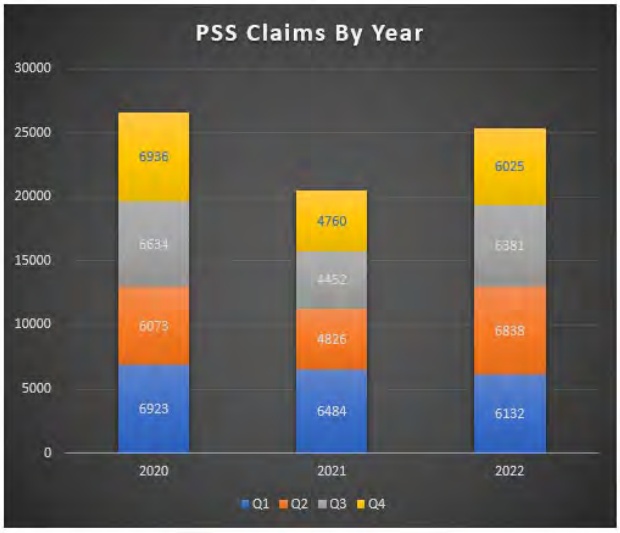
			Final Cohort Values at Start of Intervention (April 2022)		Final Cohort Values at End of Intervention (October 2022)		Difference	% change
Starting Cohort	132							
Final Cohort	115							
Number of Cohort enrolled in enhanced case management services during the 6 month intervention period	83	Potentially Avoidable Costs	$334,400	17.80%	$257,800	14.14%	3.66%	20.57%
		Total Costs	$1,878,900		$1,823,600			
		ED Visits Prior 12 Months	1209		1135		74	6.12%
		ED Visits Prior 6 Months	813		479		334	41.08%

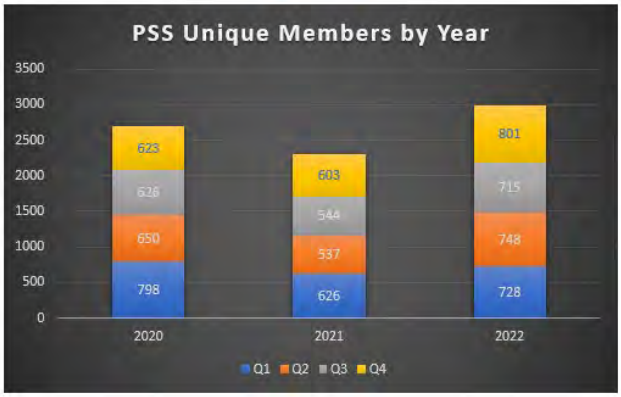
Schizophrenia with High ED Use - 2022 Sub-Cohort

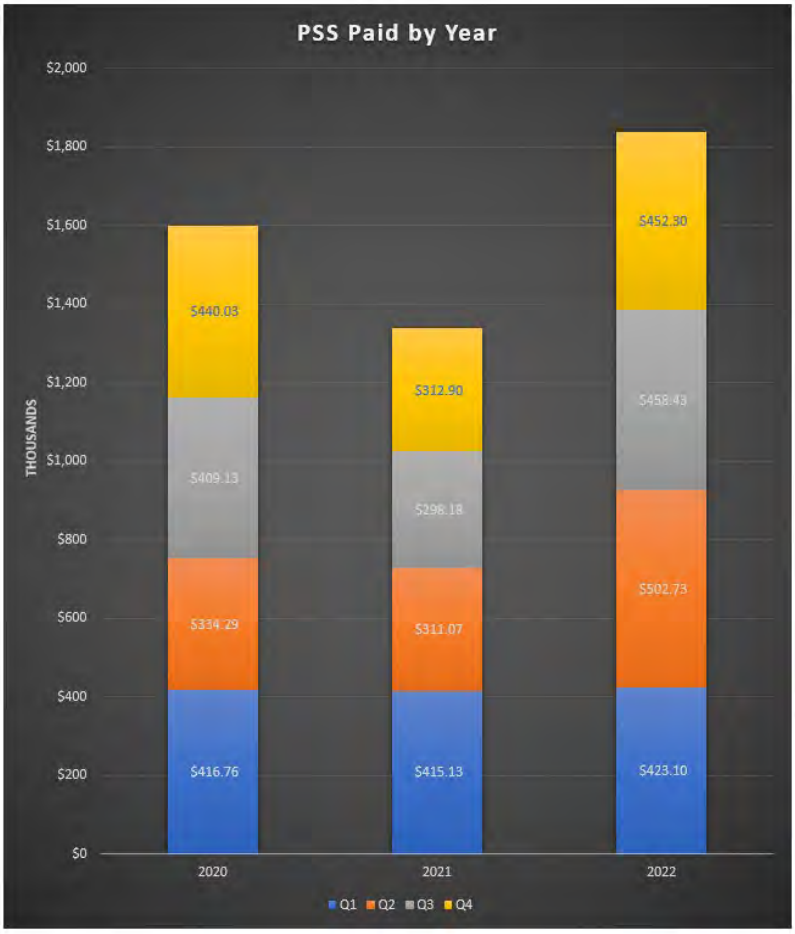
			Final Cohort Values at Start of Intervention (April 2022)		Final Cohort Values at End of Intervention (October 2022)		Difference	% change
Starting Cohort	32							
Final Cohort	29							
Number of Cohort enrolled in enhanced case management services during the 6 month intervention period	25	Potentially Avoidable Costs	$85,600	14.99%	$72,700	12.20%	2.79%	18.61%
		Total Costs	$570,900		$595,700			
		ED Visits Prior 12 Months	286		261		25	8.74%
		ED Visits Prior 6 Months	210		109		101	48.10%

Figure 7

Peer Support Services by Year and Quarter







E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

CHA will continue to provide THW services (and build capacity) through its five partnerships (3 BH providers, 1 PCPCH, and Sky Lakes Medical Center (SLMC)).

Transformations Wellness Center (TWC) has resumed its work in the ED, utilizing PSS support staff to engage SUD patients. Now that the capacity to provide trainings within an online environment has been established, trainings will continue to be held in collaboration with the BH community to further increase the community's THW capacity by still an additional twenty (20) FTE in 2023, a goal repeated after success in 2022. CHA continues to explore additional funding sources to further expand the Klamath community's ability to provide THW certification training in our community.

CHA will continue to follow its THW Integration and Utilization Plan to further increase THW capacity in the delivery network, including evaluation of best practices, internal policy, and procedure development specific to THW care coordination, and monitoring of THW service utilization. Additionally, CHA will continue to identify measurable outcomes for THW utilization to better capture and measure the effectiveness of THW services not currently captured via encounter claim data. As reporting requirements increase to include more accurate and stratified data regarding THW utilization in the Klamath community, CHA will create an active tracking and reporting system to allow for a more precise method of capturing key data points (i.e., how many providers utilize THWs, number of independent THWs active in the community, and how many unduplicated members are receiving THW services).

The 2023 updated SPMI cohort for enhanced case management, identified through will be pulled in April, and consist of members with high ED use and an SPMI diagnosis. After significant success in 2022 on this initiative, the work is being repeated to establish a consistent cadence and move the work from transformational to routine. Initial values for avoidable cost and ED visits will be updated before interventions begin in April of 2022.

Due to the nature of this intervention and its relatively small population, analysis of these cohorts by REALD data has been inconclusive due to the high amount of variance in small populations and the volume of unknowns due to incomplete REALD data in member 834 files. At a high level, no significant opportunities for directed intervention based on perceived disparity were present. As REALD data collection improves in 2023, additional analysis will follow.

New in 2023, CHA will develop a plan to collect sexual orientation and gender identity (SOGI) data during member onboarding and to stratify behavioral health and other quality data by it once collected.

The Potentially Avoidable Costs in SPMI and THW Sustainable Capacity project (OHA project #59) will support CHA's utilization management program through the utilization of Optumas, and other data sources. Additional information about the utilization management program can be found in the Utilization Review prior year assessment in Section C and continued project outcomes in Section D. As part of MEPP reporting and in alignment with TQS Utilization Review component expectations, CHA will enhance its reporting capability to better determine under- and over-utilization of services, effectiveness of interventions targeted to this population, including the following metrics in addition to what is currently gathered:

- Potentially avoidable cost for intervention cohort vs non-intervention cohort, including delta and trendlines
- Members declining intervention vs. those offered (members are defined as meeting criteria but declining or dropping case management)
- Emergency Department (ED) utilization by diagnosis (presenting and discharge) for intervention members vs. non-intervention cohort (members are defined as meeting criteria but declining or dropping intervention)
- Number of members receiving referral to THW as an intervention; accepting or declining referral

Additionally, because Optumas does not have data on all types of SPMI diagnosis, a sub-cohort will be used to compare the results of using predicted potentially avoidable cost with using the Optumas model to identify adverse actionable events (AAEs). Optumas reports on three different types of SPMI (known as episodes in Optumas): Bipolar Disorder, Depression & Anxiety, and Schizophrenia. Of the three, Schizophrenia had the highest 2020 AAE at 12.77%, which is why it was used for this sub-cohort review. CHA has identified the members in its SPMI cohort with schizophrenia and will use this sub-cohort to review both baseline and final potential avoidable cost (PAC) and AAE to compare the outputs of the two tools and more fully evaluate the intervention (See Monitoring Measure 3.4). Due to the nature of data received through the Optumas tool and the time it takes to compile, CHA will have to wait until 2022 AAE data is received (halfway through 2023) to complete this portion of the evaluation. Additionally, CHA will establish

new cohorts in 2023 to continue the intervention and develop a year over year comparison of these two tools (& Optumas).

2023 Activity 3 (MEPP Project Intervention Criteria)

This continued project, titled *PAC reduction in high ED-use members with SPMI through enhanced case management intervention*, will advance health equity by providing additional resources to a traditionally marginalized population, those experiencing SPMI, that often have challenges engaging in care. This intervention is expected to reduce PACs by engaging members in care and providing additional support services. This intervention will require redeployment of additional CHA CM and provider services. This intervention does require third party action on the part of contracted providers and coordination of care. Specifics about this MEPP project are listed below.

- **Targeted Episode of Care:** SPMI with high ED utilization with a sub-cohort of Schizophrenia for AAE to PAC comparison.
- **Potentially Avoidable Cost (predicted AAE):** Varies over time and updated to revise the cohort prior to initiating intervention activities.
- **Measure 1 (Activity 3 Monitoring Measure 3.2)**
  - **Numerator 1:** Cohort PAC at start of intervention minus PAC at end of intervention
  - **Denominator 1:** Cohort PAC at start of intervention
  - **Performance Period 1:** 4/1/23 – 10/31/23
  - **Baseline Period and Population 1:** Cohort PAC at start of intervention
- **Measure 2 (Activity 3 Monitoring Measures 3.3 and 3.4)**
  - **Numerator 2:** Sub-Cohort (Schizophrenia) PAC & AAE at start of intervention minus PAC & AAE at end of intervention
  - **Denominator 2:** Sub-Cohort (Schizophrenia) PAC & AAE at start of intervention
  - **Performance Period 2:** 4/1/23 – 10/31/23
  - **Baseline Period and Population 2:** Sub-Cohort (Schizophrenia) PAC & AAE at start of intervention
- **Definition of Success:**
  - Reduction in Cohort PAC of 10% or greater for both measures
  - Evaluate the relationship between predicted Potentially Avoidable Cost (PAC) and Adverse Actionable Events (AAE) through sub-cohort review.
- **Data Sources:** CHA Claims (& Optumas

2023 Activity 4 – MEPP Data Project and SUD work

MEPP data can be utilized in up to two projects as some other application of the MEPP data to support other quality initiatives. CHA is electing to utilize MEPP data to provide additional cost efficiency analysis of work related to SUD as part of the ongoing Initiation and Engagement in Treatment Performance Improvement Project (PIP) that supports CHA improvement for the Initiation & Engagement of Substance Use Disorder Treatment OHA Incentive Metric.

SUD remains a challenging episode for CHA with an Adverse Actionable Events (AAE) value in 2021 of 25% compared to an 18% overall AAE for all episodes. This variance indicates the potential for significant efficiency improvements in this episode. CHA currently works with its BH provider community in monthly meetings focused on all aspects of care. A dedicated section of this meeting involves discussions around SUD and how the community is solving challenges faced by this population. Much of the work done in these meetings is tied to efficiently identifying members with an SUD diagnosis and referring them to care for engagement. The goal of this activity is to measure the reduction SUD AAE as a result of these ongoing activities and bring it closer to the overall CHA AAE of 18%. Success will be measured using the MEPP dashboard, Optumas, over the next two years. Originally, there was an SUD AAE target of 20% for 2022 MEPP

data (available mid-year 2023), but after reviewing 2021 rates and existing interventions, it's unlikely that target will be achieved. It will still be monitored for performance and an updated target of 20% (instead of 16%) for 2023 MEPP data (available mid-year 2024) has been established.

When reporting MEPP projects in TQS, the expectation is that they be included as part of the Utilization Review component. As such, this IET MEPP Data Project and its updates will be housed within this project (OHA Project #59, *Potentially Avoidable Costs in SPMI and THW Sustainable Capacity*) as it deals with both cost reduction and mental illness, both of which are associated with AAE and SUD.

F. **Activities and monitoring for performance improvement**:

Activity 1 description: Increase community capacity of THW/CHW/Peer Recovery Mentors/Support Specialists through curriculum development, program execution; create mechanism for sustainability of education and certification program.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Monitor the number of newly trained THWs (Community Health Workers/Peer Wellness Specialists/Peer Support Specialists/Doulas/Patient Health Navigators).			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
In 2022 20 THW trainings were completed	THW training for at least 20 more individuals are scheduled	09/2023	THW training for at least 20 individuals is completed	12/2023

Activity 2 description: Use predictive analytic platforms/tools to identify the target cohort; assign the cohort members for intervention; develop targeted, individualized, integrated care plans.

☒ Short term or ☐ Long term

Monitoring measure 2.1	Continue to identify SPMI cohort members; establish targeted and individualized care plans for cohort members.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
New 2023 SPMI Cohort identified in April	Active care plans for 25% of cohort members are established	07/2023	Active care plans for at least 50% of cohort members are established	10/2023

Activity 3 description – MEPP Intervention Project: Monitor cohort to measure reduction in PAC and/or AAE. Targeted interventions are individualized with achievement based on individual member performance. PAC and/or reduction for the entire cohort monitored monthly with performance used to inform PDSA cycles for continued improvement opportunities.

☐ Short term or ☒ Long term

Monitoring measure 3.1	Identify metrics and database; create reporting platform; review and analyze data.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Cohort metrics include number of members identified, number with active care plans, potentially avoidable costs, and ED visits.	Additional metrics identified if needed and reports built, including visualization.	05/2023	Metrics aggregated, reviewed, and analyzed monthly.	7/2023
Monitoring measure 3.2	**MEPP Intervention Measure** – Reduce PAC of case managed members with SPMI and high ED use. (Source:			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
2023 Cohort starting PAC (as of 4/1/23)	Reduce Cohort PAC by 5%	07/2023	Reduce Cohort PAC by 10%	10/2023
Monitoring measure 3.3	**MEPP Intervention Measure** – Record PAC of Schizophrenia sub-cohort members with SPMI and high ED use. (Source:			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
2023 Sub-cohort starting PAC (as of 4/1/23)	Sub-cohort ending PAC	10/2023	Calculate % change PAC and compare with monitoring measure 3.4	10/2023
Monitoring measure 3.4	**MEPP Intervention Measure** – Record AAE% of Schizophrenia sub-cohort members with SPMI and high ED use. (Source: Optumas)			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
2022 & 2023 Sub-cohorts starting AAE% as identified in Optumas	Sub-cohorts ending AAE% (Optumas 2023 & 2024 data)	08/2023	Calculate % change AAE and compare with monitoring measure 3.3	08/2023

Activity 4 description, MEPP Data Project: Reduce adverse actionable event (AAE) of substance use disorder (SUD) episode through performance reporting and best practice sharing with primary care clinics.

☐ Short term or ☒ Long term

Monitoring measure 4.1	**MEPP Data Measure** – substance use disorder (SUD) AAE% (Source: Optumas)			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**

SUD episodes contain approximately 25% AAE in 2021	SUD episodes contain approximately 20% AAE	12/2022 (data available August 2023)	SUD episodes contain approximately 20% AAE	12/2023(data available August 2024)

A. **Project short title**: Collaboration and Care Coordination for LTSS FBDE Population

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project

If continued, insert unique project ID from OHA: 368

B. **Components addressed**

i. Component 1: SHCN: Full benefit dual eligible
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this is a CLAS standards project, which standard does it primarily address? Choose an item
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

In 2021, Cascade Health Alliance (CHA) had two special health care needs (SHCN) projects, one focused on members with diabetes, and the other focused on those receiving long term services and supports (LTSS). SHCN split into two components in 2022, one for members with SHCN who are not full benefit dual eligible (non-FBDE) and one for members with SHCN who are full benefit dual eligible (FBDE). Continuing into 2023, the Holistic Diabetes Management project (OHA project #366) will report on non-FBDE members with SHCN while this project (Collaboration and Care Coordination for LTSS FBDE Population – OHA project #368) will focus on FBDE members with SHCN.

Cascade Comprehensive Care (CCC) is a health care management company that operates Klamath County's coordinated care organization (CCO), CHA, and serves as a local administrator for ATRIO Health Plans (ATRIO), a Medicare Advantage (MA) plan. During 2022, CCC, in collaboration with ATRIO Corporate, managed care for 140 full benefit dual eligible (FBDE) long-term services and supports (LTSS) members who were identified as LTSS and enrolled in both CHA and ATRIO's Special Needs Plan (SNP) all at the same time. The targeted FBDE SNP LTSS population, as well as the remaining FBDE SNP population, was case managed per the model of care (MOC) as written for all FBDE members. A written health risk assessment (HRA) was mailed to the member with a request to complete it and mail it back. If the HRA was not returned within thirty days, up to three telephone calls were made to members to try and complete the HRA over the phone. All members, even those for whom an HRA was not completed, were mailed a care plan with goals based on their health status and additional follow-up with their assigned nurse case manager was scheduled within three to six months. CHA includes caregivers in interdisciplinary team (IDT) meetings, care plan goal setting and discussions to increase support of their work. From Aging and People with Disabilities (APD) and Developmental Disability Services (DDS), CHA can request a copy of a caregiver's service plan for review of unaddressed needs.

Further prior year assessment of the SHCN: Full benefit dual eligible component is included within section D as the Collaboration and Care Coordination for LTSS FBDE Population (OHA Project #368) includes infrastructure enhancements that will impact the entire FBDE SNP population with SHCN despite a focus on the LTSS population.

Please see the following attached as supporting documentation for this project:

- Final ATRIO CHA Collaborative Care Workflow

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

Although CCC and ATRIO regularly collaborate to meet the needs of LTSS members and made great strides towards improvement in 2023, the infrastructure to collaborate across lines of business consistently and efficiently for purposes of screening and providing care coordination services continued to be inefficient. CHA and ATRIO care management platforms are not interoperable, making it challenging for each entity to access progress notes, care plans, or confirmation that a member is being actively managed by one entity or the other. Because CHA and ATRIO systems do not easily communicate with each other, information sharing is labor intensive, and some efforts are likely duplicative. Each entity is conducting assessments and collecting information sometimes from the same member leading to multiple contacts with members, and ultimately, frustration of members with the number of duplicate contacts. CHA and ATRIO each have a designated case manager who monitors Transfers of Care, including discharges from short-term and long-term hospital and institutional stays, and generating member care plans when needed. Both CHA and ATRIO monitor members at higher risk for readmissions and refer members to additional case management as appropriate. Despite both organizations having these systems in place, CHA and ATRIO have not historically collaborated efficiently to monitor transitions of care plans nor work to reduce hospital readmissions.

In 2021, CHA and ATRIO regularly discussed how to improve workflows to alleviate these challenges, but to date, improvements are mostly have been workarounds using systems and resources available. CHA and ATRIO made great strides in making improvements to infrastructure to improve collaboration and efficiency; this included enhancing the integration of DSNP Case Management. CHA and ATRIO better aligned member needs with the type of available case management. ATRIO supplies long-term, low-risk case management while CHA provides acute, high-risk case management through Intensive Community Care Management (ICCM). In addition to initiating the process to improve how LTSS members are managed, CHA and ATRIO established a similar partnership and process with APD. Even though CHA was previously included in care conferences where APD was present, CHA has not historically otherwise engaged with APD to provide services to members. While ATRIO had staffing changes directly related to this work in 2022, CHA opted to focus its efforts on the CHA LTSS population overall and capturing applicable data to capture data for LTSS MOU reporting. CHA also continued to improve the partnership between CHA and APD and working together to assist members through the Memorandum of Understanding (MOU) with Aging and People with Disabilities (APD). The MOU guides collaboration and information sharing between APD and CHA for members with LTSS while enhancing integration of services. The MOU improves member experience by supporting the comprehensive and integrated collaborative care coordination workflow referenced in section E. Additionally, CHA now has a flag in CHA's case management system, which allows CHA and ATRIO Case Managers to easily identify members receiving LTSS. ATRIO is planning on adding a similar LTSS flag to its case management system in 2023. This will allow ATRIO Case Managers to more easily and efficiently identify LTSS member as they will not need to look in two systems. Case Managers can also now easily look in to show all members who are enrolled, in process, referred, or have an inpatient case status (essentially those that are open or referred to CM). CHA also continued to use the LTSS cohort within Collective Medical to better track the LTSS population's utilization of emergency services.

Progress on this project was slow in 2022 due to high demand for case management services and challenges presented by staffing changes at both organizations. Data sharing, processes, and communication improved; however, CHA and ATRIO are still working on implementing workflows (see collaborative care workflow attached) and finding solutions to barriers that inhibit streamlined collaboration and standardized reporting. This project focuses on LTSS members with SHCN; however, processes will ensure any FBDE SNP member with SHCN receives care coordination, care planning, and management of care transitions with the goal of appropriate access to care and improved health outcomes.

2022 Monitoring Activity Updates:

- **Activity 1 (Enhance current infrastructure through a documented comprehensive collaborative care coordination plan which includes data and information sharing.):** A collaborative care workflow was finalized to document the current process. CHA and ATRIO Case Managers have a good process to collaborate when working with a shared member. CHA and ATRIO will need to continue to work on making the process more efficient and automated to decrease duplication and manual entry. As far as data and information sharing goes, APD sends CHA a monthly LTSS report. CHA then filters the report down to only ATRIO members and sends it to ATRIO. This allows both CHA and ATRIO to know who the FBDE LTSS members are. Due to bandwidth constraints and implementation of system enhancement, automated data and information sharing has not yet occurred. The other monitoring activities will remain active as CHA and ATRIO collaborate to improve current workflows and implement new ones. CHA implemented a method to capture the percentage of Annual IDT meetings completed by CHA-ATRIO-APD/AAA teams for LTSS SNP FBDE members. Since this occurred in the middle of 2022, data might not have been fully captured and the report might not be fully capturing work completed in 2022. Data capture should improve in 2023.
- **Activity 2 (Prioritize high-needs LTSS members and holistically understand all LTSS members.):** CHA and ATRIO utilize the LTSS report from APD to identify LTSS members in need of case management services. Health Risk Assessments (HRAs) are used to prioritize members with highest need, to better understand members holistically, and to help update care plans. In 2022, 89% (125 of 140 members) of FBDE SNP LTSS members completed an ATRIO Health Risk Assessment (HRA). This is an improvement from 2021 when 48% (104 of 216 members) of FBDE SNP LTSS members completed an ATRIO Health Risk Assessment (HRA) and from 2020 when only 42% of LTSS SNP members completed an HRA. The target of 75% was reached, so the target will be updated for 2023. The total LTSS members likely decreased due to improved reporting. Care plans are regularly updated every 90 days. In 2022, 0% of care plans for high risk LTSS SNP FBDE members receiving case management were updated at least every 90 days and shared with all relevant parties. Of note, care plans are manually shared with relevant parties. CHA enhanced data capture capabilities in 2022 to better identify which care plans are shared. However, it reliant on manual entry and implementation was slow, so reports might not fully capture completed work.
- **Activity 3 (Utilize current and new processes to improve data capture and reporting for quality and incentive metrics and other measures specific to the LTSS FBDE population to inform quality improvement and care coordination efforts.):** Due to the issues mentioned above, CHA and ATRIO did not create a full LTSS FBDE quality dashboard in 2022 as originally planned for monitoring measure 3.1. However, CHA did create a three-phased plan to develop the dashboard based on the measures identified in 2021. A draft dashboard for phase 1 measures is shown below in Figure 8. The three phases of the plan are:
    - Phase 1 EHR Measures: Screening for Depression and Follow-Up Plan, Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control, Smoking Prevalence, and Drug or alcohol misuse screening (SBIRT).
    - Phase 2 Claims Measures: All-cause readmissions, Ambulatory care: Avoidable emergency department utilization, Disparity Measure: Emergency Department Utilization among Members with Mental Illness.
    - Phase 3 Prevention Quality Indicators (PQI) measures: PQI 01: Diabetes short-term complication admission rate, PQI 05: COPD or asthma in older adults' admission rate, PQI 08: Congestive heart failure admission rate, and PQI 15: Asthma in younger adults' admission rate.

  Additional quality measures may be added upon completion of Phase 3. As shown in Figure 8, the LTSS population primarily has better rates for Phase 1 measures. As the dashboard reaches full implementation, REALD and other demographic data will be added to allow stratification for the exploration of disparities. Currently, this is explored ad-hoc, but it will be implemented into standard views of the LTSS dashboard. New in 2023, CHA will develop a plan to collect sexual orientation and gender identity (SOGI) data during member onboarding and to stratify LTSS and other quality data by it once collected. Monitoring measure 3.2, Holistic member profile (member-level data found in dashboard), will be discontinued as this work is being absorbed into monitoring measure 4.4 of OHA Project #61, Closed-loop Grievance System TQS project.

Figure 8

2023 LTSS FBDE EHR Metrics

Starting 2023 Population	140
Final 2023 Population	
Number of Cohort with an active Atrio HRA	125

	2022 OHA EHR Metrics		2023 OHA EHR Metrics		LTSS Difference	LTSS % change
	CHA Overall	LTSS FBDE	CHA Overall	LTSS FBDE		
Smoking Prevalence	25.30%	15.79%				
Diabetes Poor Control	27.30%	21.88%				
Depression Screening	35.40%	44.83%				
SBIRT Screening (Rate 1)	48.10%	57.14%				
SBIRT Intervention (Rate 2)	62.60%	0%*				

*This measurement had a very small denominator in 2022

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

In collaboration with ATRIO, Cascade Health Alliance (CHA) will continue to follow the documented comprehensive and integrated collaborative care coordination workflow which includes:

- Identification of members in need of or currently receiving Medicaid funded LTSS services (be they Medicaid primary or FBDE covered)
  - High health care needs
  - Multiple chronic conditions
  - Mental illness or substance abuse disorders
  - Functional disabilities or live with health or social conditions that place them at risk of developing functional disabilities
  - LTSS members who otherwise meet SHCN population as defined by the OAR
- Revision of current processes and workflows for service provision, coordination (including the identification of barriers to care, coordination with the member's PCP and other applicable parties, medical treatment plan compliance, medication compliance, disease-specific teaching, and identification of social determinant of health needs), follow up, and monitoring of members
- Reduction in duplication of services (including services related to discharge planning for short-term and long-term hospital and institutional stays)
- Comprehensive data monitoring and analysis plan to include:
  - Outreach efforts and members engaged in services
  - Services provided
  - Members served and actively case managed
  - ED utilization
  - Depression Screening and Follow-up
  - Plan All-Cause Readmissions
  - Chronic diseases (including, but are not limited to, diabetes, congestive heart failure, asthma, and COPD) and complications of and health outcomes related to those chronic diseases)
- Identification of improvement opportunities to improve health outcomes and target health disparities
- Formal staff training curriculum development based on Atrio's SNP Model of Care (MOC)
- Mutual accessibility to all necessary member information and reporting

Streamlined processes will continue to improve data capture, contact with and screening of LTSS members, and care coordination as well as standardize communication, reduce all-cause readmissions, increase screening for depression and follow-up, decrease avoidable emergency room utilization, and improve health outcomes. As part of streamlining processes, CHA and ATRIO will develop methods to quantify disease prevalence across the member population. This will guide efforts in targeting specific health concerns and develop interventions to improve outcomes. The Closed-loop Grievance System (OHA Project #61) TQS project further supports these efforts through the development of a comprehensive Health Equity Dashboard with aggregate data and an enhanced member profile with member specific data. LTSS efforts in 2023 will continue to focus on a couple LTSS MOU reporting measures to align efforts with the LTSS MOU deliverable. Efforts will continue to focus on the development of the quality measure dashboard and start to focus on phase 1 LTSS dashboard health outcome measures to transition this project to a data centric model.

CHA and ATRIO will continue to enroll identified members in appropriate Case Management programs to address care coordination needs with a person-centered, holistic plan of care developed in collaboration with the member and/or caregiver and reviewed in monthly Interdisciplinary Team (IDT) meetings to ensure appropriate coordination and provision of services. Interdisciplinary care teams include providers that are relevant to the members health care needs, and at minimum the member and/or designated caregiver, Primary Care Provider, and Nurse Case Manager. Other care team members may include, but are not limited to, long-term care community nursing (LTCCN) services, Aging and People with Disabilities (APD), Developmental Disability Services (DDS) supports, adult foster homes, and assisted living facilities. The team address member access to appropriate providers (i.e., primary health, specialty, behavioral health, and dental providers), reduction in barriers to care, identification of local resources, and addressing polypharmacy. Members are connected with local resources as needed through Healthy Klamath Connect (Community Information Exchange) which has a closed loop referral system to ensure members receive services for social needs.

New in 2023, CHA will develop a plan to collect sexual orientation and gender identity (SOGI) data during member onboarding and to stratify LTSS and other quality data by it once collected.

F. **Activities and monitoring for performance improvement**:

Activity 1 description: Enhance current infrastructure through a documented comprehensive collaborative care coordination flow which includes data and information sharing.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Improve data and information sharing for streamlined care coordination.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Manual but more consistent (compared to 2021) data and information sharing	Continue and finalize the development of processes and systems for consistent and automated data and information sharing	12/2023	Utilize shared data and member information to streamline care coordination	12/2024
Monitoring measure 1.2	Utilize IDT meetings as outcome measure to demonstrate success of an enhanced infrastructure for comprehensive collaborative care coordination			

	which includes data and information sharing. This aligns with the CCO 2.0 Deliverable CCO-APD/AAA MOU Summary Annual Report.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% of Annual IDT meetings completed by CHA-ATRIO-APD/AAA teams for LTSS SNP FBDE members (Method to capture applicable data implemented was implemented half-way through 2022, so reporting might not be fully reflective of work completed.)	50% of Annual IDT meetings completed by CHA-ATRIO-APD/AAA teams for LTSS SNP FBDE members	12/2023	100% of Annual IDT meetings completed by CHA-ATRIO-APD/AAA teams for LTSS SNP FBDE members	12/2024

Activity 2 description: Prioritize high-needs LTSS members and holistically understand all LTSS members.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Increase completion rate of annual HRA screenings.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
89% (125 of 140 members) of FBDE SNP LTSS members completed an ATRIO Health Risk Assessment (HRA) in 2022	95% of FBDE SNP LTSS members complete or update their HRA	12/2023	Same as target	Same as target
Monitoring measure 2.2	For LTSS members receiving case management, care plans are regularly updated and shared with all relevant parties. Care plan completion time for this measure is based on Medicaid (CHA) requirements since CHA is held to a stricter timeline than ATRIO. CHA must complete care plans every ninety (90) days while ATRIO must complete them every six (6) months.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% of care plans for high risk LTSS SNP FBDE members receiving case management	50% of care plans for high risk LTSS SNP FBDE members receiving case management	09/2022	100% of care plans for high risk LTSS SNP FBDE members receiving case management	03/2023

were updated at least every 90 days and shared with all relevant parties. (Care plans are manually shared with relevant parties. CHA enhanced data capture capabilities in 2022 to better identify which care plans are shared. However, it reliant on manual entry and implementation was slow, so reporting might not be fully reflective of work completed.)	are updated at least every 90 days and shared with all relevant parties		are updated at least every 90 days and shared with all relevant parties	

Activity 3 description: Utilize current and new processes to improve data capture and reporting for quality, health outcome, and other measures specific to the LTSS SNP FBDE population to inform quality improvement and care coordination efforts, beginning with the following:

- Outreach efforts and members engaged in services
- Services provided
- Members served and actively case managed
- ED utilization (per contract)
- Depression Screening and Follow-up (per contract)
- Plan All-Cause Readmissions (per contract)
- Chronic diseases (including, but are not limited to, diabetes, congestive heart failure, asthma, and COPD) and complications of and health outcomes related to those chronic diseases

CHA will utilize data from multiple sources, including, but are not limited to, HRAs, claims, Collective Medical, Reliance, and LTSS reports from APD to improve health outcomes of the LTSS SNP FBDE population.

☐ Short term or ☒ Long term

Monitoring measure 3.1	Dashboard creation.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
CHA created a draft dashboard for phase 1 measures	Create and finalize dashboard with	06/2023	Create and finalize dashboard to	12/2023

	phase 1 and phase 2, and phase 3 data		include phase 3 data	
Monitoring measure 3.2	Current rate maintained or improved for Screening for Depression and Follow-Up Plan OHA Incentive Metric for LTSS Population (aligns with LTSS MOU Reporting)			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
44.83% (26 of 58 members) of FBDE SNP LTSS members were screened for depression and had a follow-up plan if needed	44.83% of FBDE SNP LTSS members were screened for depression in 2023 and had a follow-up plan if needed	12/2023	If depression screening rate maintained during 2023, new health outcome measure(s) identified and tracked	12/2024

Section 2: Discontinued Project(s) Closeout

(Complete Section 2 by repeating parts A through D until all discontinued projects have been addressed)

A. Project short title: N/A. [There are not any discontinued projects.]
B. Project unique ID (as provided by OHA): N/A
C. Criteria for project discontinuation: Choose an item.
D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words): N/A

Section 3: Required Transformation and Quality Program Attachments

A. REQUIRED: Attach your CCO's quality program documentation as outlined in TQS guidance:
   1. Quality Assurance and Performance Improvement (QAPI) Workplan
   2. QAPI Impact Analysis
   3. QAPI Plan PP09007
      i. Also supports the following TQS projects: OHA Projects # 366, #59
   4. Utilization Measures Review, Analyzation, and Remediation PP09007.01
      i. Also supports the following TQS projects: OHA Projects #366, #59
   5. Quality Management Data Use PP09005
   6. Quality Metrics Dashboard DP09005.01
   7. Health Promotion PP09006
   8. Screening of High Risk and Prioritized Populations for Opioid Use Disorders PP09006.01
   9. Quality Management Committee Charter
   10. Quality Management Committee Minutes
   11. Compliance Committee Charter
   12. Compliance Committee Minutes
   13. Provider Network Management Committee Charter
      i. Also supports the following TQS projects: OHA Project #366
   14. Provider Network Management Committee Minutes
      i. Also supports the following TQS projects: OHA Project #366
   15. Utilization Review Committee Charter
      i. Also supports the following TQS projects: OHA Projects #366, #59

16. Pharmacy and Therapeutics (P&T) Committee Charter
17. Pharmacy and Therapeutics (P&T) Committee Minutes
18. Utilization Review Committee Agendas and Minutes
    i. Also supports the following TQS projects: OHA Projects #366, #59
19. 2022 Member Demographics Dashboard
    i. Also supports the following TQS projects: OHA Projects #61, #33
20. 2022 Grievance Report
    i. Also supports the following TQS projects: OHA Project #61
21. 2022 Appeals Report
    i. Also supports the following TQS projects: OHA Project #61
22. 2022 Denials Report
    i. Also supports the following TQS projects: OHA Project #61

B. OPTIONAL: Supporting information

- Attach other documents relevant to the TQS components or your TQS projects, such as policies and procedures, driver diagrams, root-cause analysis diagrams, data to support problem statement, or organizational charts.
    i. This list of attachments is in addition to the ones listed in Section 3 Part A.
    ii. Appeals/Grievances 2022 Provider Training (includes Provider Dismissal of Member training) (OHA Project #61)
    iii. Grievance and Appeal System Policy and Procedure (OHA Project #61)
    iv. Provider Dismissal of Member Policy and Procedure (OHA Project #61)
    v. 2022 Provider Dismissal Dashboard (OHA Project #61)
    vi. Healthy Klamath Connect (HKC) Flyer (OHA Project #33)
    vii. HKC Training (OHA Project #33)
    viii. Establish SDOH Screening and Referral Process performance improvement project (PIP) (OHA Project #61, #33)
    ix. Draft Person-Centered Primary Care Home (PCPCH) Comprehensive Plan (OHA Project #365)
    x. Patient centered Primary Care Home Policy & Procedure (OHA Project #365)
    xi. Medication Therapy Management (MTM) Process [MTM plan] (OHA Project #366)
    xii. CHA Member Spend Year-Over-Year (OHA Projects #366, #59)
    xiii. Final ATRIO CHA Collaborative Care Workflow (OHA Project #368)
- Describe any additional CCO characteristics (for example, geographic area, membership numbers, overall CCO strategy) that are relevant to explaining the context of your TQS: See *Additional Cascade Health Alliance (CHA) Characteristics* below.

Additional Cascade Health Alliance (CHA) Characteristics:

Klamath County is located in southern central Oregon and spans nearly 6,000 square miles with a population of roughly 69,400, with approximately 35% of the population enrolled in Cascade Health Alliance. Klamath County is considered rural, and in some areas, frontier, making transportation key to accessing healthcare services. CHA is one of the "Core Four" agencies that serve as the guiding force behind the Healthy Klamath partnership which is a coalition (Healthy Klamath Coalition) comprised of over 50 local Community Benefit Organizations (CBOs), health providers, and Klamath County Public Health who collaborate at every opportunity to improve the health of the community. In addition to its strong partnerships with Klamath healthcare providers and community benefit organizations, CHA has established close partnerships with the two local higher education entities, Oregon Institute of Technology and Klamath Community College, to leverage limited local resources to improve the health of our community, including workforce development.

The county is predominantly white (88%) and English speaking (93%). The current demographic data shows that 95% of CHA members prefer English, with the remaining 5% either not reporting a preferred language or indicating that they prefer Spanish (4.6%) or another language. Additionally, the World Population Review estimates that 7.8% of Klamath County residents speak Spanish as their first language, which is not reflected in the 4.6% who identify as speaking Spanish within CHA's data. CHA continues to monitor and address the growing cultural and linguistic needs of its members and to meet or go beyond OHA's expectations for providing language assistance (when 5% of members or 1000 members declare the need) to ensure that all members have equal access to information even if they did not formally declare a need for language assistance. Through continued and regular demographic data analysis, identified gaps will be addressed through multiple projects noted in this document.

CHA's Transformation and Quality Strategy (TQS) reflects this direction with projects focusing on activities to better facilitate CHA's understanding of underlying social issues within our community through data collection and reporting, the need to be more culturally responsive to members and their cultural needs and be more responsive to members with special health care needs, mental illness, and multiple chronic conditions. CHA's performance improvement projects both support and supplement the work outlined in the TQS as well as support the full execution of CHA's Health Equity Plan. Additionally, TQS is also utilized for CHA's Quality Assurance and Performance Improvement (QAPI) plan evaluation and Medicaid Efficiency and Performance Program (MEPP) reporting.

Submit your final TQS by March 15 to CCO.MCODeliverableReports@odhsoha.oregon.gov.

2023 Quality Assurance and Performance Improvement Plan

TQS Section 3.A REQUIRED

Contents

Quality Management Team
Chanel Smith, Director Quality and Equity
Patricia Pahl, Health Equity Manager
David Elliott, Quality Management Analyst
Sherrie Ardolino, Quality Transformation Coordinator

QAPI Review
Original date: March 01, 2023
Revision date:
Quality Management Committee review:
Executive Leadership review:
Board of Directors review:

Quality Strategy

As part of Oregon's Health System Transformation, the goal of Cascade Health Alliance's Quality Assurance & Performance Improvement (QAPI) Work Plan is to work towards achieving the Quintuple Aim: Better Health, Better Care, at a Lower Cost, while improving the well-being of the workforce and advancing Health Equity.

Better Health Cascade Health Alliance (CHA) is committed to efforts contributing to better health for our members. All activities involved in the provision of better care and lower costs have the ultimate goal of improved health outcomes. We focus on care coordination and intensive case management for individuals who suffer from chronic diseases to reduce costly hospitalizations, improve health, and increase quality of life.

Specific objectives for better heath:

- Continual assessment of the health status of our members through frequent evaluation of state performance Incentive Metrics and internal metrics for chronic disease and multiple co-morbidities.
- Reduce the proportion of adults with diabetes who have an A1c value above 9 percent.
- Reduce ethnic, racial, and cultural disparities in health status through involvement with Office of Equity and Inclusion initiatives, the DELTA program, community collaboration, and the development of an organization-wide equity and inclusion program to emphasize the diverse member population being served.

Better Care CHA focuses on continual improvement of the quality, access, and experience of care provided to our members. We use rapid cycle interventions to continually plan, assess, and revise our approach to improvement in all performance measure areas and performance improvement projects.

Specific objectives for better care:

- Incentive metric performance improvement
- Robust alternative payment methodologies
- Performance Improvement Projects (PIPs)

Lower Costs CHA is committed to furthering efforts to lower costs while providing better care to our members.

Specific objectives for lower cost:

- Meet or exceed 90th percentile national Medicaid benchmark for ED visit rates

- Meet or exceed national Medicaid benchmark for all cause readmissions
- Identify and assess no-show trends in an effort to lower ED use and increase access to care

Prevent Workforce Burnout CHA understands the importance of providing access to tools and resources to address provider burden and burnout and continues to find ways to reduce administrative burden of data entry and quality reporting as well as foster a culture of collaboration with other providers.

Specific objectives for Workforce Wellbeing:

- Assist in overcoming key challenges
- Provide technical assistance and suggested skills that can be implemented into daily practices
- Convey information relevant to specific workflows and demands
- Create improved learning opportunities that maximize effectiveness
- Provide financial resources to improve EHR usability

Health Equity CHA recognizes that the first step in addressing health equity is identifying disparities. Disparities extend beyond the racial factor. It's known that those of low socio-economic status face healthcare disparities. There are disparities based on gender and sexual identification. There are differences between rural and urban populations that are very substantial. CHA is committed to understanding disparities within our community and building a system to address them, thus improving the achievement of the above quadruple aim.

Specific objectives for Health Equity

- Identify disparities
- Design and implement evidence-based interventions to reduce them
- Invest in equity measurement
- Incentivize the achievement of equity

To achieve the Quintuple Aim and the specific objectives of our Quality Strategy, CHA has formulated a QAPI Plan with detailed benchmarks, milestones, and goals to achieve. The CHA QAPI Plan is aligned with the Transformation Quality Strategy and addresses the 5 basic elements of quality assessment and performance improvement programs as indicated in both 42 CFR § 438.330 and Exhibit B –Part 10, Sec 2 and 7 of our contract with the Oregon Health Authority.

CHA's 2023 QAPI Plan includes quality management activities, evaluated based on an interval schedule for each item. Specifically, CHA will provide updates in the following areas:

- Performance Improvement Projects, as referenced later in this plan
- Appeals, Complaints, and Grievances, as referenced later in this plan

- Quality metrics as determined by the OHA
- Over/Under Utilization
- Long-term services and supports

I. 2023 Quality Goals and Objectives

1. Decrease PCP no-show rates of CHA members by 5% by December 31, 2023.

2. Diabetic A1C Outreach
   2.1 Outreach and engage 50% of diabetic members who did not get an A1c checked in 2022 by June 1, 2023.
   2.2 Outreach and engage 50% of diabetic members who did not get an A1c checked in first 6 months of 2023, by December 31, 2023.

3. Grow staff understanding of membership diversity through distribution of quarterly equity dashboard by 10% by December 31, 2023.

4. Develop staff equity and diversity training and train majority of employees by December 31, 2023.

Quality Work Plan

CHA has developed a QAPI Plan, which delineates how we provide oversight to all areas of quality within our organization and how we monitor and measure the success of our improvement metrics and projects.

I. Quality Management Structure

CHA's Quality Management department is composed of one Director and five functioning staff members that complete and oversee the various quality improvement, assurance, and evaluation functions outlined in this plan.

The responsibility to monitor and/or provide oversight for the processes and activities of quality management, case management, utilization, customer service, access to care, and quality of care are delegated by the CHA Board of Directors to a hierarchal structure of the Quality Management Committee and its subcommittees. The QMC provides oversight through meetings held eight times per year, while the subcommittees convene monthly, and no less than once quarterly.

The activities of the **Quality Management Committee (QMC)** and Quality Management department are reported to CHA's Board of Directors through CHA's Chief Medical Officer, Director of Quality and Equity, and Chief Executive Officer. See figure 1 below for a list of activities under the purview of the QMC.

Figure 1 Quality Management Committee oversight

Transformation Quality Strategy	Adverse Events Monitoring
Member Material Review	Clinical Practice Guidelines
Policies and Procedures	Cultural Competency Training
Audit Monitoring	Technology Plan Review
Performance Improvement Projects (PIPs)	Provider Trainings
Provider Credentialing/Re-Credentialing	Annual Quality Strategy and Work Plan Review
Delegation Oversight for sub-contracted providers	

Utilization monitoring, appeals and grievance activities, and clinic guidelines and oversight are under the purview of **CHA's Utilization Review Committee (URC)/Clinical Advisory Panel**. The URC is comprised of local specialists and primary care providers, who provide expertise regarding second opinions, reconsiderations, and appeals, including monitoring of over/under

utilization and hospital readmissions. See figure 2 below.

Figure 2 Utilization Review Committee oversight

Authorizations	ED Utilization Monitoring
Over and Under Utilization Monitoring	Access Monitoring
Hospital Readmissions Monitoring	PCP Utilization
Disease/Medical Management Program Monitoring	Clinical Advisory Panel (Clinical Oversight and Guidance)
Benevolent Fund Requests	Appeals and Grievances Program
Second Opinions/Case Reviews	Individual Appeals & Reconsiderations

The Provider Network Management Committee (PMNC) is created to perform analysis, assessment, and identify areas of opportunity for provider network adequacy and capacity to serve the CHA membership. The committee is comprised of CHA leadership from Finance, Operations, Medical Management, Member Services, Clinical Operations, Claims, Quality & Health Equity, Compliance, Grievance & Appeals, and Credentialing. Network Adequacy Data Reporting is integrated to encompass the following focus areas:

- Member Demographics
- Primary Care Physical (PCP) and Primary Care Dental (PCD) Capacity
- Primary Care Physical and Dental Provider Performance Dashboards
- Specialty Providers by Category and Network Status
- Disease Prevalence
- Grievance and Appeals Data
- Language and Interpretive Services
- Secret Shopper Surveys for
    - o PCP/PCD
    - o Specialty Providers; and
    - o Behavioral Health

The Pharmacy & Therapeutics Committee (P&T) serves in an evaluative, educational, and advisory capacity that will focus on actions that will encourage the use of safe and effective use of pharmaceutical agents that will produce the desired outcomes of drug therapy in a cost-effective manner. The P&T Committee is comprised of Practitioners engaged in active practice from a variety of specialties who participate in the medication-use process, CHA's Chief Medical Officer, Director of Pharmacy, and Clinical Pharmacist(s). The committee is responsible for:

- Ensuring access to clinically sound and cost-effective medications.
- Overseeing the effective and efficient operation of the formulary system and drug policy development.
- Making formulary recommendations that minimize therapeutic redundancies and maximize cost effectiveness.

- Developing and managing policies for formulary management activities including prior authorization, step therapies, quantity limitations, and other drug utilization activities that affect access.
- Support the establishment of procedures to assist CHA in executing and implementing operational performance improvement initiatives.

The Compliance Committee activities include those delegated to it by the CHA Board of Directors in support of the Compliance Program for the organization and is comprised of 3 members of the CHA Board, CHA's Chief Executive Officer, CHA's Chief Operating/Security Officer and CHA's Compliance Officer. In so doing, the Compliance Committee ascertains the acceptability of proposed activities when weighed against organizational commitments, goals, regulations, applicable laws, and standards of professional conduct and practice. The responsibilities of the Compliance Committee include, but are not limited, to the following:

- Help ensure compliance objectives are being adequately addressed and high impact compliance risks are identified, assessed, and reported to the CHA Board of Directors.
- Identify, review, and assess compliance/risk issues brought forward by CHA Senior Leadership, employees, external stakeholder and plan members and other risk framing information sources.
- Create a compliance risk response plan that includes prioritizing high-risk areas and making recommendations for addressing risk areas.
- On-going assessment of progress with compliance work plans.
- Present Annual Report of activities to QMC and the CHA Board of Directors.

II. Quality Management Activities

CHA Quality Management staff, at the direction of the QMC and respective subcommittees, accomplish quality management activities in coordination with CHA staff from key departments outlined above. Activities are chosen based on CHA's strategic plan (developed collaboratively by the Operations Council), the Community Health Improvement Plan (CHP), and recommendations from the Community Advisory Council (CAC).

Each department involved is responsible for providing monthly or quarterly reports (depending on the schedule of the report's production) to the QM Department for inclusion in the QMC meeting packet. Meeting packets are distributed to QMC members no less than one business day prior to the meeting for Committee review. The QM Department compiles the following data and/or formal reports for presentation to the QMC at regularly scheduled meetings:

- Performance on all OHA Quality Incentive Metrics overall and by individual Providers/Clinics
- Quarterly PIP reports as submitted to OHA
- TQS and subsequent TQS progress reports

- Quarterly grievance and reports as compiled by the Compliance Department, and including those grievances and complaints emanating from all subcontractors
- Initial and Re-Credentialing files (clean as approved by the Medical Director in accordance with established Credentialing Policies; or unclean for review, discussion, and disposition by the QMC)
- Any concerns raised through scheduled reviews of licensing board actions, Office of the Inspector General (OIG) and/or System for Award Management (SAM) routine monitoring
- Utilization review data, reports, and/or quality of care concerns as presented by the UR staff
- CCC's performance on applicable Medicare Advantage Stars Measures
- Member experience data (any data required for DSN)

Figure 3 Quality management activities

Activity	QM	Compliance	Pharmacy	CM/UR	PNMC	Start / Target End
Over/Under Utilization Monitoring	x	X	X	X	X	Daily/Ongoing
ED Utilization				X		Daily/Ongoing
MH/SUD Utilization				X		Daily/Ongoing
Specialist Utilization	X			X		Daily/Ongoing
PCP Utilization/Access Monitoring	X			X		Daily/Ongoing
Other Utilization as warranted	X	X	X	X	X	Daily/Ongoing
Policies and Procedures Review/Update	X	X	X	X	X	1 July/ 31 Dec
Clinical Guidelines Review/Update	X			X		1 July/ 31 Dec
QAPI Work Plan	X					1 Jan /15 Mar
PIPs	X					Quarterly Review
SDOH	X					Monthly/ Ongoing
PCPCH	X					Monthly/ Ongoing
Statewide IET	X					Monthly/ Ongoing
Statewide MH Access	X					Monthly/ Ongoing
Audits	X	X	X	X	X	Varies
Provider Audits					X	Annually/as needed
Chart Audits	X					1 Jan / 31 Mar
UR Audits				X		1 Jan / 30 Sep
Claims Audits	X					1 Jan / 31 Oct
Subcontractor	X	X				Annually/ as needed
Access Auditing	X				X	1 Oct/ 31 Dec
Fraud, Waste & Abuse Monitoring		X				Monthly/ Ongoing
Medical Management Program			X	X		Varies
High Utilizers	X		X	X		Monthly/ Ongoing
Top Diagnoses	X			X		Monthly/ Ongoing
ED Visits				X		Daily/ Ongoing
Hospital Readmissions				X		Monthly/ Ongoing
Transitions of Care				X		Monthly/ Ongoing
Intensive Care Case Management				X		Monthly/ Ongoing
Special Healthcare Needs				X		Monthly/ Ongoing
Severe and Persistent Mental Illness				X		Monthly/ Ongoing
HRS/ Flexible Spending	X					As Needed/Ongoing
Health Risk Assessments				X		Daily/Ongoing
Adverse Event Monitoring	X			X		As needed/Quarterly
Grievance and Appeals Program		X				Daily/ Ongoing

Credentialing		X				Monthly/ Ongoing
Cultural Competency /Sensitivity Training	X				X	Annually
Metrics	X					Weekly/ Ongoing
Provider Training	X				X	Quarterly-PCP/ Bi-Annually-Specialists
Technology Plan	X					1 Jan/ 15 Mar
External Quality Review		X				Annually
Transformation Quality Strategy	X					1 Jan / 15 Mar
Community Advisory Council Attendance	X					Monthly/ Ongoing
Health Equity Plan	X					31 Mar/ 15 June

III. Performance Improvement Measurement

The Quality Management department team utilizes the PDSA (Plan, Do, Study, Act) cycle to perform rapid cycle improvement on all measures and projects. This provides a framework for ongoing assessment and revision to interventions. The PDSA cycle is applied in the design and operation of performance improvement projects, annual quality work plan, and other projects under the prevue of the QM team.

Figure 4 PDSA for rapid cycle improvement

To assess the quality of care received by plan member, the Quality Management team

analyzes data collected from the appeals and grievances process, state quality metrics, designated internal metrics, and plan diversity. Through this data analysis, the team can identify trends that will help to pinpoint areas for improvement. The sections below outline the primary projects that will be the focus of the 2023 Quality Strategy.

A. Appeals and Grievances

CHA has policies and procedures in place for appeals, notice of adverse benefit determinations (NOABDs), hearings, and grievances. In 2022, the Compliance Committee continued to have ultimate oversight over member grievances and appeals, including quarterly monitoring of all data and Corrective Action Plans. CHA trains staff, community advisory council (CAC), and provider network on the grievance and appeal system annually. All members have access to information regarding the grievance and appeal system in CHA's member handbook and website.

CHA has monthly grievance, appeals, and provider dismissal dashboards and quarterly authorization denial (NOABD) dashboards. So far, only the grievance and provider dismissal dashboards are stratified by race, ethnicity, and language. Most of the grievance and appeal data comes from internal sources; however, TransLink (non-emergency medical transportation, NEMT, provider) and Klamath Basin Behavioral Health (KBBH) provide additional, external data. Member grievances are reviewed monthly by the Provider Network Management Committee (PNMC). Concerns raised during regular monitoring of subcontractors and/or delegated entities either through the annual audit process or regular data submission are also brought to the PNMC for review and action if necessary.

In 2022, the top three (3) grievance categories were Provider/Plan (39 grievances), Access to Care (33 grievances), and Consumer Rights (16 grievances). These were the same top three (3) grievance categories as 2021 (Access to Care (44 grievances), Provider/Plan (48 grievances), and Consumer Rights (19 grievances). The service types with the highest grievances in 2022 were: dental (32 grievances; 30% of total grievances), Primary Care Provider (PCP; 23 grievances; 22% of total grievances), and other (25 grievances; 23% of total grievances). The overall number of grievances decreased significantly from 2021 (132) to 2022 (107) with a 19% reduction overall. This decrease was likely due to more providers and clinics returning to near-pre-pandemic availability and capacity.

Related to health equity, in 2022, CHA had zero grievances regarding "provider's office has a physical barrier/not ADA compliant, prevents access to office, lavatory, examination, room, etc."; however, one clinic had a grievance regarding "provider/plan bias barrier (age, race, religion, sexual orientation, mental/physical health, marital status, Medicare/Medicaid)". The grievance was from a member who felt they were not being treated with respect regarding dismissal from care. It was explained to the member that their complaint was not an issue of disrespect, but a general policy regarding missed appointments.

As far as appeals are concerned, 2022 data shows the following services accounted for most appeals: specialty care (41%), dental (16%), imaging (14%), and pharmacy (11%). This differs in several places compared to 2021 where DME (9%) was nearly three times as frequent as Imaging (3%), and the opposite was true in 2022. Overall, most of the appeals and denials in 2021 and 2022 continue to be related to services that are not considered medically appropriate/necessary and denial or reduction in quantity of services. This continues to be an educational opportunity for both members and providers.

To help facilitate identifying trends of poor member experience, CHA utilized multiple sources of member experience data and reporting methods to further investigate findings found through grievance and appeal data. Data sources and reporting methods include but are not limited to: OHA, Healthy Klamath, County Health Rankings, Healthy Klamath Connect, CHA's Community Advisory Council (CAC), Delivery Service Network (DSN) Narrative and Capacity Report, Patient-Centered Primary Care Home (PCPCH) enrollment, service utilization and claims, and Language Line utilization. However, due to the broad nature of member experience data and its many sources, current data related to member experience is scattered amongst multiple reports, at times outdated by the time it is reported, not member or topic specific, or not easily accessible by CHA. This causes in-depth analysis of member experience data to be inefficient and potentially duplicative.

Improvement opportunities include aggregation of data from multiple sources, collection of additional data points when gaps are identified, and conversion of data into more easily actionable information for use both internally and by the provider network. CHA identified these challenges and improvement opportunities in 2020 and continued working on changes in 2021 and 2022.

Strengthening CHA's data collection and reporting structures, including stratification of data by REALD, continued as a high priority for CHA in 2022. More comprehensive data reporting will allow for more robust data analysis which will enable CHA to better connect members to community resources through the CIE, HKC, and provider generated resources to improve member experience with our local healthcare system.

Race, ethnicity, language, and disability (REALD) and sexual orientation and general identity (SOGI) can affect member experience and health outcomes. In 2021, CHA worked on developing a process to stratify grievances and appeals data by REALD status. This includes member reassignment and provider dismissal data captured within grievance and appeal reporting. Collection and analysis of this data may provide further insight into why members file a complaint (grievance), as well as identify additional opportunities for CHA to better serve members and improve health outcomes. Since CHA was unable to complete and implement the stratification of grievances and appeals by REALD in 2022 due to bandwidth limitations, CHA will complete implementation in 2023.

B. Incentive Metrics

The OHA utilizes fourteen incentive metrics to promote assess to consistent and quality care and assess the quality of care received by CHA members.
CHA uses these metrics to perform internal and external quality review and analysis of care, access, and cost. CHA strives to meet or exceed the improvement targets as set forth by OHA. In 2021 results demonstrate that CHA exceeded improvement targets for all but one metric (Cigarette Smoking Prevalence was 0.1% from meeting the improvement target), earning 114% of available Quality Pool Funds allocated for the CCO by OHA. Funds earned are distributed back to participating providers, including SDOH-E and public health partners

As of this writing, the 2022 results were not finalized, CHA was able to complete an initial review of the 2022 results by utilizing our internal MY 2022 dashboard released in March of 2023.

The 2022 CCO Quality Incentive Program consists of 14 measures:

Adolescent Immunizations	HbA1c Poor Control
Alcohol & Drug Misuse Screening (SBIRT Rate 1 & 2)	Health Equity: Meaningful Language Access (attestation/ 80% data collection) *
Assessments for Children in DHS Custody	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment*
Childhood Immunizations	Oral Evaluation for Adults with Diabetes
Cigarette Smoking Prevalence	Postpartum Care
Depression Screening and Follow Up	Preventive Dental ages 1-5 and 6-14*
Health Aspects of Kindergarten Readiness - Social Emotional Health	Well Child Visits 3-6 years*

*Challenge Pool Metric
Metrics in bold were new for 2022

Of the fourteen metrics identified above, CHA is on track to meet eleven (Childhood & Adolescent Immunizations, SBIRT Rate 1 & 2, DHS Assessments, Smoking Prevalence, Depression Screening & Follow up, HAKR, HbA1c Poor Control, Diabetic Oral Evaluations, Postpartum Care, Preventative Dental ages 1-5 & 6-14). After working with primary care practices through our monthly provider engagement meeting where best practices and current workflows are collaboratively shared, it was discovered that depression and SBIRT screenings were being done, but reporting was not accurately capturing these efforts. For 2022, the SBIRT and depression screening metrics were met due in large part to a focus on EHR improvements and refining reports to accurately capture all structured data at the major primary care practices in Klamath County,

including Sky Lakes, Cascades East and Sanford Pediatric. This significantly increased our demonstrated performance rates by 12.4% for Depression Screening, 27.1% (Rate 1) and 57.7% (Rate 2) for SBIRT Screening. This led to the discussion and discovery that more technical assistance on Metric reporting specifications was desired. For 2023, CHA hired a Quality Transformation Coordinator to work directly with practices by providing best practices in clinical workflows, and assistance with EHR documentation/reporting workflows.

CHA continues to work towards improving Member Language Access, data collection, and reporting abilities. In the absence of bilingual providers or staff, CHA provides access to a language line for CHA staff, member, and provider use. CHA's ability to report on the utilization of the language line is improving as CHA has contracted a new language line vendor who can now provide member-level data. However, some network providers do not use CHA's contracted language line, which limits CHA's ability to collect, aggregate, and analyze language access data for all member visits, and there is no systematic way to collect, aggregate and analyze data on the number of services provided by bilingual providers or their bilingual staff. With improved data processes, CHA will be able to more accurately analyze member-level language utilization data to guide the future identification of gaps, improvement opportunities, and solutions. During 2022, CHA focused on the Year 2 attestation objectives related to gathering member-level encounter data from providers. While ultimately successful in gathering additional information on services provided for this population, CHA was unable to collect the desired volume of responses from the network with only 27% of eligible encounters being reported on. This encounter data was used to produce reports demonstrating current performance and these are shared with the provider network in metrics-focused meetings. The focus for 2023 will be on achieving Year 3 requirements of the self-assessment for the MLA incentive Metric tied to wait times reporting and increasing the volume of data received from providers around this work. Included in this focus will be the continued refining of our updated database and the production of improved language reports that include additional details around members who require interpreter services.

Quality Management is committed to improving our performance on all fifteen-incentive metrics in 2023, and have identified the following for metrics as the focus of 2023:

- Screening & Referrals for Social Determinants of Health & Equity
- Meaningful Language Access
- HbA1c Poor Control
- Oral Evaluations for Diabetics

In efforts to meet the targets of these four and hopefully all fifteen metrics, staff will continue monthly clinic engagement meetings to provide clinic-level and patient-level data indicating clinic performance on all metrics, with recommendations for

improvement in the areas where the clinics are not meeting standards. In 2022, these clinic engagement meetings provided the most significant performance-monitoring tool, in that many issues among EHR and data collection were identified and addressed based on the conversations these meetings facilitated.

In addition to improving the performance of these four metrics, clinics participating in the monthly clinic engagement meetings provided feedback that they'd like to focus on addressing one of the most common barriers seen in the Klamath Basin community, which is high No-Show rates. For 2023, CHA will work with clinics to gather information on no-shows from all clinics to analyze trends seen. Process and workflows will be developed to enhance member outreach to provide education on the importance of keeping appointments to hopefully increase engagement, reduce ED visits, and lower costs.

Through Community Advisory Council (CAC) membership, QM will continue to work with council members to understand how incentive initiatives and other interventions can be tailored to the needs and wants of the community more effectively. The CAC also provides community oversight for survey and focus group campaigns, as many organizations active in Klamath County can provide access to membership and other low-income residents that may not be covered under OHP. Throughout 2023, QM staff plan to present different incentive programs and recruitment strategies to the CAC in order to ascertain community buy-in when possible.

C. Over/Under Utilization Management

CHA's utilization management program currently includes authorization and utilization review of medical, behavioral health, dental, and pharmacy services with review conducted by the Case Management and Pharmacy departments, with overall oversight by the Chief Medical Officer, the Utilization Review Committee (URC), and Pharmacy and Therapeutics (P&T) Committee. CHA completes monthly inter-rater reliability (IRR) for randomly selected medical, behavioral health, and dental authorizations. Findings of reliability below 85% are referred to the case management department for process improvement.

CHA utilization review (UR) staff spend most of their time processing and reviewing authorizations, appeals, and reconsiderations (provider appeals). CHA staff, P&R Dental, and URC members process appeals and reconsiderations (provider appeals).

Multiple reports are currently used to monitor utilization with some being produced regularly and others ad hoc. CHA consistently tracks utilization for certain services but does not currently have an integrated approach to monitoring utilization leading to an opportunity for more in-depth analysis and identification of improvement opportunities. CHA tracks utilization of high priority preventive services and percent of assigned members seen by primary care medical and dental providers. CHA sets targets for these services and provides feedback to providers on a regular basis. CHA tracks a

balanced measure set that includes over- and under-utilization, access measures, quality measures, medical complexity, and member complaints. All measures are reviewed monthly by the appropriate and responsible CHA departments, CHA leadership, and CHA's Quality Management Department to ensure medically appropriate, high-quality care is provided to CHA members. CHA provides monthly performance dashboards to providers which detail performance toward the incentive metrics targets by clinic, as well as risk scorecards which include ED and generic drug utilization. Additionally, CHA uses claims data monthly to track professional, primary care, behavioral health, inpatient, institutional, outpatient, dental, and pharmacy utilization and spending over time. CHA utilizes Optumas, through the Medicaid Efficiency and Performance Program (MEPP), and other tools to identify potentially avoidable cost (PAC) and adverse actionable events (AAE) for improvement opportunities. CHA's annual provider audits include a chart review to ensure services are accurately documented. Outside of TQS, CHA is building additional capacity and workflows to collect and monitor utilization using reports that are generated from claims on a monthly cadence. These reports will include primary care, specialty care, behavioral health, institutional, pharmacy and dental claims data with the ability to evaluate trends based on REALD and SOGI information, when available, to help identify and act on disparities in utilization. In addition, CHA reviews utilization on a on a case-by-case basis for members identified as high utilizers.

CHA continues to improve workflows and build capacity to more regularly produce all types of utilization monitoring needed to better identify improvement opportunities. Examples demonstrating CHA's methods to actively monitor utilization of services over time include, but are not limited to, the Peer Support Specialist (Figure 6) and SPMI/SUDs & Chronic Disease Cohorts (Diabetes, or CHF, or COPD, or Asthma) (Figure 7) dashboards.

Figure 6 Peer Support Services by Year and Quarter

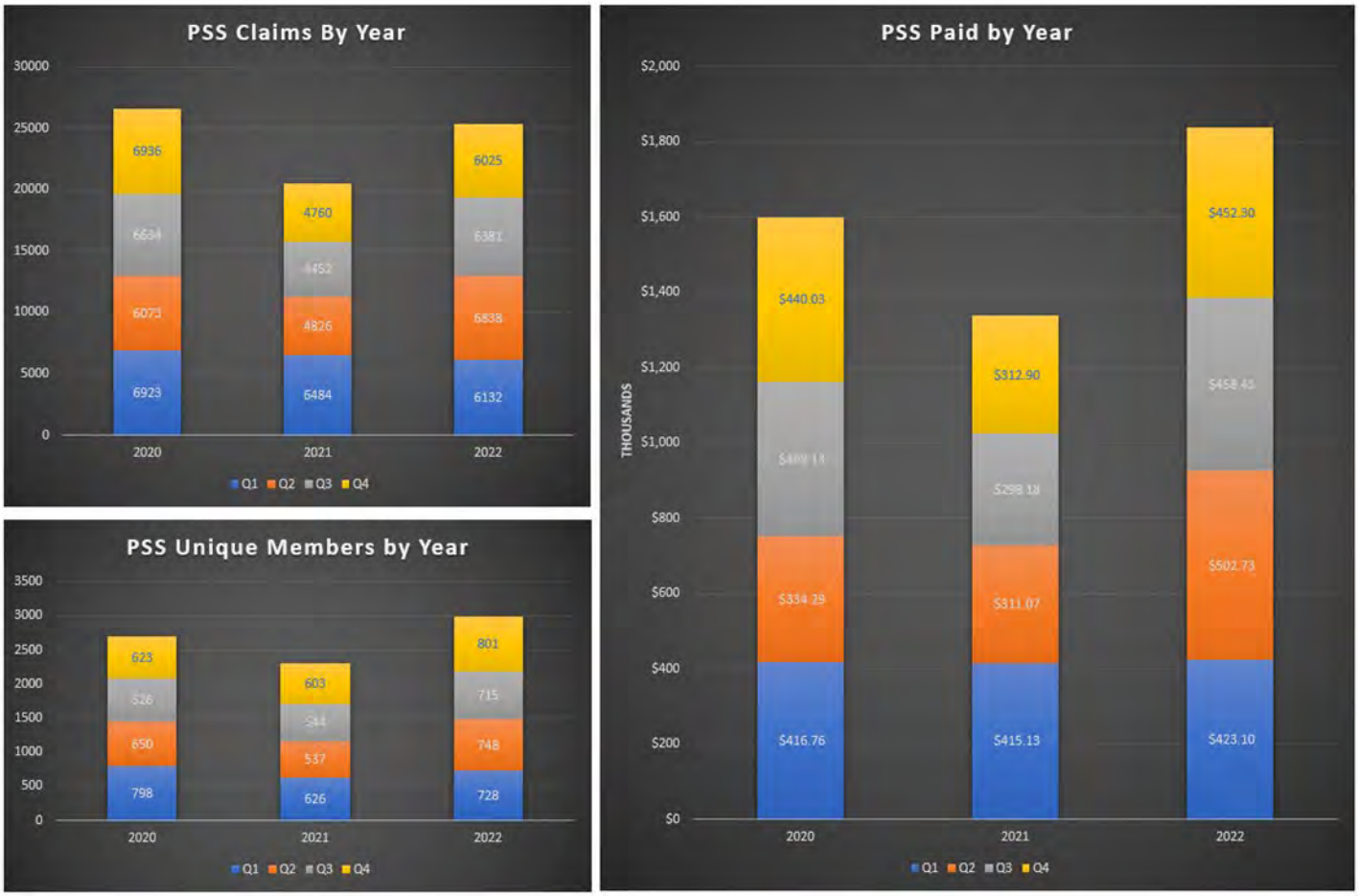


Figure 7 Potentially Avoidable Costs in SPMI and THW Sustainable Capacity

Schizophrenia with High ED Use - 2022 Sub-Cohort

			Final Cohort Values at Start of Intervention (April 2022)		Final Cohort Values at End of Intervention (October 2022)		Difference	% change
Starting Cohort	32							
Final Cohort	29							
Number of Cohort enrolled in enhanced case management services during the 6 month intervention period	25	Potentially Avoidable Costs	$85,600	14.99%	$72,700	12.20%	2.79%	18.61%
		Total Costs	$570,900		$595,700			
		ED Visits Prior 12 Months	286		261		25	8.74%
		ED Visits Prior 6 Months	210		109		101	48.10%

SPMI with High ED Use - 2022 Cohort

			Final Cohort Values at Start of Intervention (April 2022)		Final Cohort Values at End of Intervention (October 2022)		Difference	% change
Starting Cohort	132							
Final Cohort	115							
Number of Cohort enrolled in enhanced case management services during the 6 month intervention period	83	Potentially Avoidable Costs	$334,400	17.80%	$257,800	14.14%	3.66%	20.57%
		Total Costs	$1,878,900		$1,823,600			
		ED Visits Prior 12 Months	1209		1135		74	6.12%
		ED Visits Prior 6 Months	813		479		334	41.08%

In 2023, CHA will enhance its reporting capability to better determine under- and over-utilization of services, effectiveness of interventions targeted to this population, including the following metrics in addition to what is currently gathered:

- Potentially avoidable cost for intervention cohort vs non-intervention cohort, including delta and trendlines
- Members declining intervention vs. those offered (members are defined as meeting criteria but declining or dropping case management)
- Emergency Department (ED) utilization by diagnosis (presenting and discharge) for intervention members vs. non-intervention cohort (members are defined as meeting criteria but declining or dropping intervention)
- Number of members receiving referral to THW as an intervention; accepting or declining referral

CHA will also utilize Optumas to monitor adverse actionable events (AAE) related to episodes of diabetes. Using Collective Medical, Transitions of Care processes, Healthy Klamath Connect (HKC), and other tools, processes, and resources, CHA staff will work with members to limit the number of emergency department (ED) and avoidable inpatient admissions.

D. Performance Improvement Projects (PIPs)

CHA currently has two areas of focus for our PIPs and two additional areas designated as Statewide PIPs. In 2022, CHA successfully implemented a new PIP focused on Social Determinants of Health Screening and Referrals, to help focus efforts on alignment with the new OHA incentive metric. This new PIP took the place of CHA's previous Diabetes PIP, which integrated into a focused workgroup and is captured through CHA's Transformation Quality Strategy (TQS). At the end of Q4 2022, CHA retired its IET PIP as the work was absorbed into the Statewide IET PIP.

QM staff continue to improve the quality of documentation provided in OHA reports, specifically around PIPs. Improvements will be made through enhanced documentation and planning of PIPs prior to notification.

CHA's ongoing PIPs include continuous oversight, intervention, and review by QM staff and both the QM and UR committees.

1. Member Experience (PCPCH Tier Increase) PIP

Patient-Centered Primary Care Homes (PCPCH) are instrumental in improving health outcomes, lowering the cost of healthcare, and improving patient and provider experience (quadruple aim) through their ability to offer multiple services. A 2016 OHA study found that a clinic can save $28 per member, per month after three years of having a PCPCH designation while also reducing utilization rates for specialty office visits, radiology, and emergency department. Member experience with the healthcare system effects health outcomes in that

individuals are more capable of improving their health when they understand how to do so and are active participants in their care plan. According to John Hopkins, better member experience also increases revenue and decreases cost. Medical cost is 5.3% lower for members who receive enhanced decision-making support, and the least activated patients have 21% higher costs.

Despite the efforts of Primary Care Clinics to improve care, members do not rate the local healthcare system highly. CHA Adult CAHPS data show members are not happy with the healthcare system: Rating of Health Care (63.3%) and Rating of Health Plan (61.89%) are rated lower than most individual items surveyed. Both ratings are lower than the State average (71.87% and 71.28%, respectively). Similar themes are present across Cascade Comprehensive Care's (CCC) Medicare Advantage (MA) plan CAHPS data. Grievances and appeals data also show dissatisfaction with the healthcare system. Current data related to member experience is outdated, not member or topic specific, and in some cases not accessible by CHA; Making it challenging to identify the root causes of low satisfaction ratings by members.

The aim of this PIP is to enhance clinic engagement to influence PCPCH tier advancement for 66% (2 of 3) of 4 Star clinics and working with 25% (1 of 4) of non-PCPCH clinics to become a PCPCH clinics by Q3 2023. The following interventions are in place:

a. Through engaging with the PCPCH SAC, CHA's Quality Director received access to a resource that identifies current clinic tiers, Standards attestation, and site verification timelines. This will be used to further engage clinics around tier advancement.
b. Create intentional provider communication by utilizing a monthly clinical newsletter. The CareTalk newsletter revamp continued in Q4 of 2022 with establishing a cadence of article production by various members of the CHA medical management team with an expected bi-monthly release starting in Jan 2023. Distribution will utilize provider e-mails included in credentialing files with an 'Opt Out' structure to ensure maximum network saturation.

2. Establish SDOH Screening and Referral Process

Unmet social needs, such as food, transportation, and housing status, play a significant role in health outcomes. Disparities have become particularly more pronounced during the immediate public health emergency. Identifying SDOH factors and connecting members to services is essential for improving health as the Center for Disease Control (CDC) cites that 60% of avoidable deaths can be attributed directly to social, environmental, and behavioral factors, while only 10% are related to clinical

care, and 30% are related to genetics. Addressing social needs requires a range of interventions based on individual situations and priorities. In addition to screening and referring for SDOH needs, members need a central resource that can connect them to local community benefit organizations (CBOs) to assist them in meeting their social needs.

CHA currently lacks a systematic approach to screening members for unmet social needs, referring to community resources, and collecting data from providers and community-based organizations that screen and refer members. Due to uncoordinated efforts by CHA staff, clinics, and other local organizations, the current screening and referring process is inconsistent and data is not easily reportable or sharable. This has led to duplicate efforts where multiple organizations are working with the same member and could also limit connecting some members to community resources.

Previous SDOH screening efforts identified that staff feel uneasy when asking SDOH screening questions to members and members are hesitant to answer some of the questions in the screening tool. This may stem from cultural differences related to discussing social needs issues or lack of relationship prior to asking personal social questions. With motivational interviewing and improved SDOH screening tool training, staff may be more comfortable discussing social needs topics which would help improve the screening rate.

By December 31, 2024, CHA will build and develop infrastructure (process, training, data capture, reporting) to implement the year one and year two expectations of the SDOH OHA incentive metric.

3. Oregon Statewide PIP - Mental Health Service Access Monitoring

Improving access and utilization of mental health services has the potential to improve health outcomes for members of all ages, as well as member satisfaction. Increased access to mental health services can help with identifying and addressing emerging mental health issues early before they become significant problems which improves members' health and lives.

When looking at overall performance and the performance of each stratified age group compared to state averages over the same period of time, we saw that CHA members generally outperformed the state average (58.4%), indicating that there are no unique local barriers that are significantly impacting Klamath County differently than other regions of the state. With a focus on equity for all age ranges, CHA is prioritizing interventions for the 65+ population who is the primary performance outlier for this measure. Once performance of the 65+ population nears the averages for other age ranges, interventions will be able to expand to wider audiences or refocus on outlier populations identified in remeasurement periods.

Significant barriers to elderly access of mental healthcare have been identified.

Commonly occurring among barrier lists is the general lack of education around the utility and availability of care. This has also been observed in the CHA community as part of conversations around mental healthcare with partners and community organizations. To reduce this barrier, CHA will engage in an education campaign by distributing literature to local community partners, Community Based Organizations, Primary Care Providers, and other spaces. In addition, CHA will discuss and distribute this information among local behavioral health clinics as part of CHA's regular monthly 'BH Providers Meeting'.

The intent is to measure the effectiveness of community education as a means of increasing MH Access. While it has been determined that an education and awareness campaign will be the intent of this PIP work, the specifics of what education needs to be shared with this community, with what frequency, and with what method of distribution are still being developed. Text messages to members may not be particularly effective tools for our 65+ target population, so other approaches may be necessary. Some manner of mixed media will be explored during Q4 2022, with more research on the effectiveness of information delivery methods being conducted as well. Q1 2023 should be message development and print media commissioning with a Q1 2023 expected start of distribution. This should allow changes in 2023 performance to be compared against passive attainment in baseline years 2021 and 2022 that had little directed focus with this population and this measure.

4. Oregon Statewide PIP – Initiation, Engagement and Treatment of Alcohol and Other Drugs Use Disorders

When the IET metric was first proposed, the Quality department at CHA looked at previous performance data and began educating our provider network on the metric specifications. Through this process it was discovered that there are some significant barriers in achieving this metric. Specifically, the lack of a system and formal process for communication amongst different provider types for referrals, intervention, treatment, and care. Additionally, previous work done in the ED utilization PIP had identified barriers in the system for referring patients to treatment services as well as information sharing amongst providers due to request for information forms being filled out incorrectly and therefore, a lack of communication between the referring and treating provider.

Improving communication amongst providers and establishing an effective referral system is important, especially for the coordination of care of this marginalized and stigmatized population. Despite the efforts of our providers, member initiation in treatment services for substance use disorder (SUD) was 40.7% in 2019 and member engagement was 9.4% in 2019- both well below the state benchmark. From the work that was started in the ED utilization PIP (2018-2020), the provider community recognized the gaps in the system and barriers for

substance use disorder treatment and decided to continue this work to repair the community's referral system. Project success will lead to increased utilization of treatment services, improved performance on the IET metric, and improved health outcomes for members that initiate and engage in SUD treatment.

E. Equity Focus

The Quality Management Team will continue to merge equity considerations among all aspects of member and community partner interaction, including outreach, quality metrics, and community engagement. QM will draw attention to health disparities among CHA membership and larger community through the publishing of quarterly equity dashboards that will provide snapshots of our membership. These dashboards will not only drive and focus improvements around specific distinct and vulnerable populations but will help staff and community partnerships gain a better understanding of the people our CCO serves. CHA will also continue to increase the number of raw data reports stratified by equity data while enhancing member profiles with updated equity data.

Overall, QM plans to steadily ensure the equity lens is utilized, insisting for inclusion of equitable research and interaction for programs and projects across all departments. Most current projects currently consider disparities in all aspects of the PDSA cycle, including CHA's TQS, PIPs, and Health Equity Plan. Additionally, CHA will revamp its equity training program for staff.

In addition to advocating for the equity focus among company projects, QM staff will work will the Healthy Klamath Network in achieving goals of the equity focus area of the Klamath County 2022-2025 Community Health Improvement Plan (CHIP). CHA co-leads the equity focus workgroup alongside Klamath County Public Health. Equity CHIP goals include activities related to resources, data, events, and training.

IV. Vulnerable Populations

The Quality Management Team uses a variety of data sources to identify vulnerable populations served by the CCO in Klamath County. Data from member enrollment (834s) can often provide knowledge of race, ethnicity, language, disability, and biological data. Since of CHA's membership files lack data (i.e., membership file says ethnicity is unknown, etc.), CHA continues to work on improvements to enhance data capture. While limited data does make it difficult to pull accurate reports to determine what the disparities are, QM and Business Intelligence staff regularly utilize available member demographic and population data (including REALD and SOGI data) to bolster current analysis of quality data. Quality data includes disease prevalence, health outcomes, provider assignments, access, utilization, incentive metrics, FBDE, LTSS, SDOH, grievances and appeals, and improvement project outcome measures. While current data does provide an idea of current trends and

a snapshot of our membership over time, CHA is focused on developing and enhancing availability of important population data.

Despite these many challenges, CHA has been able to identify trends among vulnerable and disparate populations that has helped to provide a more detailed understanding of our membership. Through platforms such as and Reliance HIE, CHA is able to identify diagnosis-based population information, such as SPMI, chronic disease, diabetes, and children with chronic disease.

Along with claims, EHR, and member file data, QM staff regularly utilizes Healthy Klamath and County Health Rankings websites to compare county-level data to CCO data. QM is currently focusing on Screening & Referrals for Social Determinants of Health & Equity, Meaningful Language Access, diabetes, Oral Evaluations for Diabetics, housing, transportation, and food insecurity.

QM has identified three vulnerable populations that will be the focus of CHA's quality and performance improvement goals in 2023.

A. Members with Severe and Persistent Mental Illness

The Case Management (CM) Team manages, and monitors activities related to members with SPMI as well as reporting of any concerns regarding the quality of care provided to members with SPMI to the QM Team. Multiple community integration efforts in the county are intended to promote the efficient use of behavioral health resources that can be scarce in a rural region. CHA continues to work with local partners to ensure additional training for traditional health workers (THWs) that serve the community. THWs can help identify patients in need of specific services and ensure their proper referral, or they can serve as an early intervention to mitigate issues that could increase in severity over time. By promoting additional training of THWs, CHA aims to match each member need with a qualified resource. When combined with integrated referral systems like Healthy Klamath Connect, and active monitoring of patient segments, CHA behavioral health staff is improving care by taking the initiative and being proactive with available services.

CHA will continue to follow its THW Integration and Utilization Plan to further increase THW capacity in the delivery network, including evaluation of best practices, internal policy and procedure development specific to THW care coordination, and monitoring of THW service utilization. Additionally, CHA will continue to identify measurable outcomes for THW utilization to better capture and measure the effectiveness of THW services not currently captured via encounter claim data. As reporting requirements increase to include more accurate and stratified data regarding THW utilization in the Klamath community, CHA will create an active tracking and reporting system to allow for a more precise method of capturing key data points (i.e., how many providers utilize THWs, number of independent THWs active in the community, and how many unduplicated members are receiving THW services). CHA will also continue explore additional funding sources to further expand the Klamath community's ability to provide THW certification

training in our community.

The Potentially Avoidable Costs in SPMI and THW Sustainable Capacity TQS project will support CHA's utilization management program through the utilization of Optumas, and other data sources.

B. Long-term services and supports (LTSS)

The Case Management (CM) Team manages, and monitors activities related to LTSS members as well as reporting of any concerns regarding the quality of care provided to LTSS members to the QM Team. The Utilization Review (UR) Committee has oversight of over and under-utilization of services provided to LTSS members.

In collaboration with APD, CHA is actively working on goals related to prioritization of high needs members, interdisciplinary care teams, development and sharing of individualized care plans, transitional care practices, collaborative communication tools and processes, linking to supportive resources, health promotion and prevention, and safeguards for members.

C. Members with Special Health Care Needs

Members with special health care needs (SHCN) are identified by CHA's Case Management staff to determine the members that would benefit the most from one-on-one case management, including risk and need for intensive care case management (ICCM). Most members that are actively case managed are those that full under CHA's SHCN population, including those with an active diagnosis of any mental health or substance use disorder or those with multiple chronic conditions and either physical or mental disability. The majority of SCHN members are those that have multiple gaps in care, as identified by QM staff.

Through TQS projects, CHA has identified two SHCN populations to focus efforts on. For non-dual Medicaid members with diabetes, the Holistic Diabetes Management project aims to enhance current internal and systems-level infrastructure to cultivate alignment and active stakeholder engagement to establish a holistic, patient-centered diabetes management approach to guide care coordination and the development of treatment and care transitions and to improve health outcomes and health disparities while lowering the cost of diabetes management and reducing duplicative efforts. Stakeholders include CHA staff, members, provider partners, and community partners. This project intends to utilize currently available resources and includes or impacts, but are not limited to, coordination of care, access to health and social needs services, over- and under- utilization of services, potentially avoidable cost, adverse actionable events, and OHA incentive metrics.

For full benefit dual eligible (FBDE) members in long-term services and supports (LTSS),

CHA collaborates with ATRIO Health Plans (ATRIO) on the Collaboration and Care Coordination for LTSS FBDE Population project. ATRIO is a local Medicare Advantage (MA) plan. The project enhances comprehensive and integrated collaborative care coordination workflow. Streamlined processes will continue to improve data capture, contact with and screening of LTSS members, and care coordination as well as standardize communication, reduce all-cause readmissions, increase screening for depression and follow-up, decrease avoidable emergency room utilization, and improve health outcomes. As part of streamlining processes, CHA and ATRIO will develop methods to quantify disease prevalence across the member population. This will guide efforts in targeting specific health concerns and develop interventions to improve outcomes. CHA and ATRIO will continue to enroll identified members in appropriate Case Management programs to address care coordination needs with a person-centered, holistic plan of care developed in collaboration with the member and/or caregiver and reviewed in monthly Interdisciplinary Team (IDT) meetings to ensure appropriate coordination and provision of services.

As with the other vulnerable populations analyzed in this report, CHA needs to perform additional analysis to further understand the usage trends of the members in this population. This analysis should focus on transportation, ED utilization, primary care access, and quality metrics performance to help inform current TQS projects, PIPs, Signature Programs, and care coordination efforts.

V. Care and Quality Assessment

Quality Management staff works with most CHA departments to assess the quality of care and services members receive while on our plan. Examples of these activities include collaboration with Case Management and Pharmacy Services, review and audits of care and services received through clinical, internal, and encounter validation audits, and joint development of analytics and care coordination software with IT.

CHA interacts with providers in our Delivery System Network through the development and offering of quarterly provider and cultural agility trainings, coder workshops, and care coordination seminars and summits that provide information of CCO processes and programs that support the care received by members from primary care to specialty care and dental care to behavioral health.

CHA's appeal and grievances program works closely with the authorizations and care coordination processes within Case Management, to determine if the care that members are receiving or being denied is appropriate for each member. Case Management works together with the two primary mental health facilities in Klamath County to coordinate care for members through CHA's Behavioral Health Coordinator. CHA's ICMS Coordinator and ATRIO Health Plan's lead Nurse Case Manager and CHA Medical Director meet weekly with administration and clinical staff at Sky Lakes Medical Center and primary nursing homes to

provide coordination of care for most of our dual-eligible population.

Oversight of Case Management, Claims, Members Services, and Pharmacy services are conducted by QM through internal and external review methods.

A. System Activities

Through the appeals and grievances program, quality audits, fraud waste and abuse analysis, and verification of service protocols, QM continually provides assessment of the care received by plan members both at CHA and through contracted providers.

1. Service verification is completed monthly through the mailing of services rendered letters through the Member Services department. Fifty letters are generated each month through an automated process that accounts for provider, member, date of service, and procedure description. The generation algorithm does not allow for any member to receive more than one verification letter in a calendar year or for any provider to be verified more than twice per year. Verification letters are not sent for women's reproductive, behavioral health, or pregnancy services. Through the process, letters that contain unclear service descriptions do not get sent in order to provide accurate and health literacy sensitive letters that members can understand and respond to.

   Tracking of letters sent, undeliverable, and returned with response is completed by Member Services staff through an Access database. Any letters that are returned blank or a negative response (ie. "service not received") are marked in Access and forwarded to both Director of Claims and Compliance Officer. If a member does not or cannot validate a service, the aforementioned staff attempt to call member to investigate. Typically, members confess to not understanding the description of the letter and can usually verify service verbally when provided with more information.

2. The Compliance Officer oversees the Fraud, Waste, and Abuse program and monitoring, as outlined in CHA's Compliance Program report. FWA complaints can be lodged verbally, in writing, or via email and may be done so anonymously through an email link on CHA's website.

Conclusion

CHA's QAPI Plan exists to provide guidance and structure to our QM activities as we work towards the ultimate goal of health system transformation. This Strategy helps the QM team to keep the big picture in mind and to see how all the pieces of our Quality Management Program work together in the transformation process. Our tracking mechanisms allow us to measure the impact and effectiveness of our QAPI Plan and implement results-based improvements in the coming years.

Cascade Health Alliance, LLC

Quality Assurance Performance Improvement Impact Analysis for 2022

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TQS Section 3.A REQUIRED

Cascade Health Alliance, LLC

In 2022 Cascade Health Alliance (CHA) set a strategic goal for the year that focused on evaluating and improving the QAPI plan:

Ensure all components of the CCC QAPI plan are implemented and functional	• Review 1 QAPI Component a month to ensure it is fully functional.
	  • If **not** functional, work with involved stakeholders to correctly re-deploy.
	  • If implemented and functional, look to see if any enhancements to the process can be made.
	  • All QAPI components reviewed by Q4 2022

This goal was set in anticipation of the 2022 EQR audit of Standard XII—Quality Assessment and Performance Improvement. Although the audit pertained to activities performed in 2021, the Quality Management team at CHA recognized this as an immediate area for improvement in 2022 and set out to address identified gaps to ensure the program was fully operational.

During the 2022 EQR audit, our internal preliminary findings mirrored the findings identified by HSAG:

Requirement	Finding	Required Action	Recommendations
For CCOs providing long-term services and supports (LTSS), the CCO's QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members using LTSS, including: • Assessment of care between settings • A comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable *42 CFR §438.330(b)(5)(i)* *OAR 410-141-3860(8)(d)*	CHA submitted its 2021 memorandum of understanding (MOU) with the Aging and People with Disabilities (APD) partner, which outlined the mechanisms used to assess LTSS members' care between settings and members' services received compared to their treatment plans. The MOU included the monitoring processes and measures of success for each assessment area. Within the narrative for the 2021 MOU reporting document, the CCO asserted that within all domains there were areas where no collaboration or referrals between APD and the CCO occurred. CHA also indicated difficulty in reportability, largely due to the upgrade in its electronic health record (EHR) system, which was rolled out in May 2021. The CCO reported that, prior to that upgrade, there was no way to retrieve specific reporting data, such as collaborative Inter-Disciplinary Team (IDT) meetings, screening of LTSS members, referrals to APD, or the tracking of LTSS members and their real-time hospital/ED utilization. CHA reported it has implemented interventions to correct the issues identified.	CHA must demonstrate that its QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members using LTSS, including assessment of care between settings and comparison of services and supports received with those included in the member's treatment/service plan, if applicable.	HSAG recommends that CHA implement the mechanisms identified within the narrative for the 2021 MOU reporting document and demonstrate implementation of the corrections the CCO has made to its program for 2022 to ensure appropriate reporting and accurate data for members receiving LTSS.
The CCO conducts and submits to OHA an annual written evaluation of the QAPI program and member care as measured against the written procedures and protocols of member care. The QAPI and member care evaluation includes the following: • Assessment of annual activities conducted including background and rationale • Plan of ongoing improvement activities to address gaps, which will ensure quality of care for members and overall effectiveness of the QAPI program *42 CFR §438.330(e)(2)* *OAR 410-141-3525(11)(c)*	Although CHA indicated in its *QAPI* policy that the CCO would complete an evaluation with the aforementioned components, the CCO did not complete the annual evaluation described in its policy and only completed its TQS in 2021. CHA's TQS described the health plan's targeted interventions/projects, project components, project background/context and rationale, monitoring efforts, and future plans to address issues and improve performance for those projects. The TQS evaluation was limited in scope with a focus only on the TQS-required elements and did not include an evaluation of the program measured against the CCO's written procedures and protocols of member care.	CHA must demonstrate compliance with the CCO's internal policies, including conducting an annual written evaluation of the QAPI program and member care as measured against the written procedures and protocols of member care, to include a plan of ongoing improvement activities to address gaps, which will ensure quality of care for members and overall effectiveness of the QAPI program.	

Requirement	Finding	Required Action	Recommendations
The CCO has a Quality Improvement (QI) committee that meets the following requirements: • Membership includes, at a minimum, the Medical/Dental Director, the QI Coordinator, and other health professionals who are representative of the scope of the services delivered • Maintains oversight and accountability of any delegated functions • Approves the annual quality strategy and retains oversight and accountability of quality efforts and activities performed by other CCO committees • Meets at least every two months and records minutes that include committee deliberations, recommendations regarding corrective actions to address issues identified, and review of results, progress, and effectiveness of corrective actions recommended at previous meeting *OAR 410-141-3525(11)* *CCO Contract Exhibit B Part 10(2)(c)(2)*	As described above, the *QAPI* policy described CHA's QMC as responsible for oversight of the QAPI program, with other committees and departments including the UR committee, Quality Management department, Case Management department, Provider Network Management Committee (PNMC), Compliance department, Operations Council, and Executive Approval Committee (EAC) being responsible for other quality assurance activities, as appropriate. CHA reported that quality improvement oversight was not isolated in a single group but stratified across the other committees; however, the State regulations require the QMC to maintain oversight and accountability of quality efforts and activities performed by other CCO committees. The QMC Charter described that the membership included at least five but no more than 15 external parties including contracted providers, including at minimum one physical health care provider, one behavioral health care provider, and one dental provider; partner organization administration staff, including behavioral health and dental; chief medical officer (CMO); director of quality management; quality management staff; and additional CHA staff as deemed appropriate. Meeting minutes demonstrated attendance of the appropriate staff and frequency of meetings. Meeting minutes also demonstrated the discussion of quality activities; however, deliberations were limited, with brief discussions, and many of the items only stating, "overview discussed." Although limited in detail, meeting minutes demonstrated review of results and progress, and minutes from the February, August, October, and December meetings demonstrated that recommendations regarding corrective actions to address the identified issues were made; however, the effectiveness of the corrective actions recommended at previous meetings was not discussed. Additionally, the committee meeting minutes did not demonstrate oversight and accountability of any delegated functions or approval of the annual quality strategy/QAPI policy/QAPI program description.	CHA must ensure its QMC maintains oversight and accountability of any delegated functions, quality efforts, and activities performed by other CCO committees; approves the annual quality strategy; and records minutes that review the effectiveness of corrective actions recommended at previous meetings.	HSAG recommends that CHA enhance its meeting minutes to include further details of committee deliberations.

In response to our own internal review and HSAG's findings, the following improvement plan was put in place:

LTSS – During 2022, QM worked with other internal teams (Business Intelligence and Case Management) to implement the mentioned monitoring mechanisms within the MOU. Thus, ensuring appropriate reporting and accurate data for members receiving LTSS.

QAPI Plan – During 2022, QM performed an analysis of the current QAPI program, along with the Policy & Procedures. A formal QAPI Workplan for 2023 was developed and presented to QMC on March 2nd for review and approval with plans to include in 2023 TQS reporting.

QMC Structure and Oversight – QM is proposing that all subcommittees of QMC provide quarterly reports for QMC review and approval of activities. QM will develop a standardize schedule and ensure that all appropriate discussion and activities are properly captured in meeting minutes.

Annual Review of Charters and P&P's – Consistent reviews of all Charters and P&P's as they relate to the QAPI Program was implemented in 2023. Previously these reviews were done on different rolling schedules and are now aligned and tracked to be done annually. A schedule will be posted and shared with all relevant stakeholders.

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT (QAPI) POLICY AND PROCEDURE

In this document, CCC is referenced in place of CCC and CHA.

CONTENTS

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

CCC is committed to ensuring all members are provided culturally competent care and services. We provide equal opportunity to members to obtain healthcare that recognizes their experiences, cultural diversity and needs, preferred language, and is inclusive of all protected classes: race, ethnicity, color, National origin, citizenship, religion, sex, sexual orientation, gender, gender identity, marital status, age, physical or mental disability, and veteran status.

Terms not defined in the DEFINITIONS section of this document may be found in the Glossary.

1 PURPOSE

1.1 This policy and procedure outlines the Quality Assurance and Performance Improvement (QAPI) Program. It includes all internal and external QAPI activities conducted by the Quality Management (QM) Department independent of and in collaboration with other departments and external providers and community stakeholders.

2 SCOPE

2.1 This policy applies to all staff that support the work of the Quality Management Committee (QMC) in assuring the quality of services provided to all members and their families.

3 POLICY STATEMENT

3.1 The CCC Board of Directors assumes ultimate responsibility for assuring the quality of services provided to members by contracted providers, clinics and long-term care facilities is of the highest quality and consistent with available resources within the Plan.

3.2 The CCC Board of Directors will implement changes to the Plan based on evidenced-based practices shown to have a positive or negative impact on health outcomes and member satisfaction in consultation with its established Committee structure and recommendations from staff.

3.3 The CCC Board of Directors ensures there are sufficient resources and support systems in place to implement the functions of the QM Department, including the implementation of the Transformation and Quality Strategy (TQS) and the QAPI Plan.

TQS Section 3.A REQUIRED and OHA Projects #366, #59

3.4 The QAPI Program is based on written policies, standards and procedures that are in accordance with evidenced-based and accepted medical practices and professional standards.

3.5 The quality of care provided to members is monitored regularly for consistency, appropriate utilization, adherence to evidence-based best practice, and member satisfaction with services provided through the CCC Board Committee structure. The credentialing policies and procedures, Credentialing.PP09002, further reinforce the quality of care provided to members through rigorous review of provider credentials and performance.

3.6 Identified concerns are used to inform quality improvement efforts to ensure clinical efficacy, including but not limited to the TQS, PIPs, internal process improvement, provider education, feedback and improvement plans. These Quality Improvement efforts will be led by the following entities as appropriate:

3.6.1 The Chief Medical Officer

3.6.2 Quality Management department

3.6.3 Case Management department

3.6.4 Pharmacy department

3.6.5 Provider Network department

3.6.6 Claims department

3.6.7 Member Services department

3.6.8 Compliance department

4 PROCEDURE

4.1 The CCC Board of Directors delegates to the QMC the responsibility to monitor and/or provide oversight over the following activities:

4.1.1 The Provider Credentialing and Re-Credentialing process

4.1.2 Review and approval of the TQS as presented by the QM Department and Community Advisory Council (CAC)

4.1.3 Oversight of organizational and individual clinic/provider-level performance pursuant to the Oregon Health Authority's (OHA) Quality Incentive Metrics

4.1.4 Oversight of Performance Improvement Projects (PIP)

4.1.5 Oversight and review of the quality of care provided to members based on data elements outlined within this document

4.1.6 Review of all grievances including those emanating from all subcontractors

4.1.7 Member and provider satisfaction surveys

4.1.8 Review and adoption of Clinical Practice Guidelines

4.1.9 Organizational-level performance pursuant to the Medicare Advantage (MA) Stars Measures

4.2 The Board of Directors delegates to the Utilization Review (UR) Committee the responsibility to monitor and/or provide oversight over clinical efficacy, including over/under utilization of services, through the following activities in accordance with *Utilization Measures Review, Analyzation, and Remediation PP9007.01*:

TQS Section 3.A REQUIRED and OHA Projects #366, #59

4.2.1 Case review

4.2.2 Individual appeals and reconsiderations

4.2.3 Appeals, grievances, and member complaints

4.2.4 Evaluate the coordination and integration of services within the provider network, including transitions of care

4.2.5 Over and under-utilization of services provided to members, including the use of services by members with special healthcare needs

4.2.6 Evaluation of case management and disease management programs provided by Cascade Health Alliance (CHA)

4.2.7 Review of second opinions

4.2.8 Provide expertise to CHA regarding clinical workflow and operations

4.2.9 Review and approval of relevant guidelines

4.3 Each department involved is responsible for providing monthly or quarterly reports (depending on the schedule of the report's production) to the QM Department for inclusion in the QMC meeting packet. Meeting packets are distributed to QMC members no less than one business day prior to the meeting for Committee review. The QM Department compiles the following data and/or formal reports for presentation to the QMC at regularly scheduled meetings:

4.3.1 Performance on all OHA Quality Incentive Metrics overall and by individual Providers/Clinics

4.3.2 Quarterly PIP reports as submitted to OHA

4.3.3 TQS and subsequent TQS progress reports

4.3.4 Quarterly grievance and reports as compiled by the Compliance Department, and including those grievances and complaints emanating from all subcontractors

4.3.5 Initial and Re-Credentialing files (clean as approved by the Medical Director in accordance with established Credentialing Policies; or unclean for review, discussion, and disposition by the QMC)

4.3.6 Any concerns raised through scheduled reviews of licensing board actions, Office of the Inspector General (OIG) and/or System for Award Management (SAM) routine monitoring

4.3.7 Utilization review data, reports, and/or quality of care concerns as presented by the UR staff

4.3.8 CCC's performance on applicable Medicare Advantage Stars Measures

4.3.9 Member experience data (any data required for DSN)

4.4 The QM Department is responsible for the development of the TQS and subsequent TQS progress reports in collaboration with all departments.

4.4.1 The TQS follows the TQS Guidance Document published by OHA which specifies domains requiring action.

4.4.2 The TQS outlines transformation and quality strategies for the coming year(s) based on the required domains, focuses on innovative and transformational activities and initiatives, and delineates the goals, objectives, and intended outcomes of the QAPI program.

4.4.3 Activities are chosen based on CCC's strategic plan (developed collaboratively by the Operations Council), the Community Health Improvement Plan (CHP), and recommendations from the CAC.

TQS Section 3.A REQUIRED and OHA Projects #366, #59

4.4.4 Each activity includes metrics to measure intended outcomes, targets, benchmarks, and dates against which achievement is measured.

4.4.5 Progress toward the achievement of stated goals, objectives, and outcomes is reviewed quarterly by the Operations Council.

4.5 The QM Department is responsible for initiating and facilitating PIPs based on needs identified through the review of performance data, concerns raised by members and/or the community at large, the CAC, the Community Health Assessment, the CHP, contractual requirements, or by a Board Committee.

4.5.1 A full needs assessment is conducted prior to the adoption of a PIP utilizing the following tools:

4.5.1.1 PIP Determination Matrix to ensure the project's alignment with CHA's/CCC's mission, vision, and values, business impact, and return on investment.

4.5.1.2 Change Management Plan which includes a stakeholder and resistance analysis to ensure interdepartmental and community partner support

4.5.2 PIP committees and/or work groups will include members of the QM Department, other staff as appropriate, and external community partners and stakeholders whenever possible to achieve representation from a diverse group of invested individuals and provide an objective assessment of the identified problem.

4.5.3 All PIP committees and/or work groups will establish charters to guide the group's efforts.

4.5.4 All PIPs will include a root cause analysis and/or barrier analysis to direct intervention efforts.

4.5.5 Each PIP will contain objective quality indicators to measure performance.

4.5.6 Interventions will focus on activities designed to reduce barriers to receiving appropriate or timely care, improve health outcomes, especially among disparate populations, and to sustain improvement over time.

4.5.7 PIPs are evaluated quarterly and results are reported to the QM Committee, Operations Council, and OHA.

4.5.8 PIPs will be considered "closed" if data does not demonstrate improvement despite changes made through implemented interventions.

4.6 The Case Management (CM) Department is responsible for managing and monitoring the following activities and reporting any significant concerns regarding the quality of care provided to members to the QM Department for review:

4.6.1 Members experiencing transitions in care

4.6.2 Members receiving Intensive Care Case Management (ICCM)

4.6.3 Members with Special Healthcare Needs

4.6.4 Members with Severe and Persistent Mental Illness (SPMI)

4.6.5 Distribution of Flex Funds to meet member needs otherwise not covered by CCC

4.6.6 Completion of Health Risk Assessment (HRA) for all Medicare Advantage members on the Special Needs Plan (SNP).

4.7 The UR staff is responsible for assessing the appropriateness of care provided to members through the prior authorization process, determination of over and/or underutilization of services, and communicating concerns regarding specific providers to the Provider Network Manager and the QM Department for discussion at regularly scheduled UR Committee and/or QMC meetings.

4.8 The Provider Network Management Committee (PNMC) is responsible for managing and monitoring the provider network, ensuring appropriate and timely access to care, establishment of provider contracts, and maintenance of the Provider Directory. Concerns are brought forward to the PNMC for evaluation and action if necessary.

4.9 The Compliance Department is responsible for oversight of all subcontractors and conducts audits of subcontractors annually.

4.9.1 Annual audit reports will be submitted to the Director of QM for review.

4.9.2 Final, approved audit reports and Corrective Action Plans, if applicable, will be submitted to the QMC for review.

4.10 The QM department ensures representation monthly at OHA's Quality Health Outcomes Committee (QHOC) to receive updates on health policy, incentive metrics, PIPs, and other contractual requirements related to the quality of care provided to members. Other departments are asked to participate based on the published agenda. QM staff in attendance provide a report and distribute relevant materials to members of the Operations Council as necessary.

4.11 The QM department ensures CCC representation at Atrio (CCC's Medicare Advantage Plan for both PPO and DSNP) meetings to receive and provide updates on Atrio's and CCC's Quality Program activities. QM staff in attendance provide a report and distribute relevant materials to members of the Operations Council as necessary.

5 RESPONSIBILITIES

Compliance, Monitoring and Review

5.1 The QM Department will evaluate the impact and effectiveness of its systems interventions of its quality program on an annual basis.

5.2 The annual QAPI evaluation will review and report on the following activities:

5.2.1 Oversight and activities of the QMC

5.2.2 Oversight and activities of the UR Committee

5.2.3 Assessment of the quality and appropriateness of care furnished to all members, availability of services, second opinions, timely access and cultural considerations; the assessment will include a report of aggregate data indicating methods used to monitor compliance

5.2.4 Assessment of the quality and appropriateness of care furnished to members with special health care needs, including a report of aggregate data indicating the number of enrollees identified and methods used to evaluate the need for direct access to specialists

5.2.5 Demonstration of improvement in an area of poor performance in care coordination for members with SPMI, including a report of aggregate data indicating the number of members identified and methods used

5.2.6 Report on the grievance system including complaints, notice of actions, appeals and hearings, and including a report on the grievances and complaints of all subcontractors

5.2.7 Report on the monitoring and enforcement of consumer rights and protections within the Oregon Integrated and Coordinated Health Care Delivery System and demonstrating consistent responses to complaints of violations of consumer rights and protections

5.2.8 Demonstrated participation in OHA's QHOC meeting

5.2.9 Review and assessment of the following:

5.2.9.1 CHA's performance toward the goals set forth by the TQS

5.2.9.2 Overview of PIP activities

5.2.9.3 Credentialing and Re-Credentialing process

5.2.9.4 Performance on the OHA's Quality Incentive Metrics

5.2.9.5 The data management system as it pertains to the generation of validated and actionable performance data

5.2.9.6 Performance on the MA Stars measures

5.2.10 Quality goals for the coming year

5.2.11 Other significant activities of the department

5.3 The annual Evaluation is reviewed by the Operations Council and Executive Approval Committee (EAC).

5.4 The EAC will review this policy and procedure for compliance with OHA contract and guidelines at least once a year, or as applicable.

Reporting

5.5 Data for assessing quality of care provided to members, specific treatment requests and/or outcomes, and concerns requiring further inquiry are collected from the following sources:

5.5.1 Incentive Metric performance

5.5.2 MA Stars measures performance as reported by Atrio corporate

5.5.3 Claims

5.5.4 Electronic Health Record (EHR) data

5.5.5 Encounters

5.5.6 CMS data reports distributed by Atrio

5.5.7 Risk scores

5.5.8 Referrals and Prior Authorizations

5.5.9 Peer Review, direct observation, and satisfaction and social determinants of health (SDOH) surveys

5.5.10 Sanction and Monitoring activities

5.5.11 Credentialing and Re-Credentialing activities

5.5.12 Appeals, grievances and member complaints; including those of all subcontractors

5.5.13 Annual medical record reviews for provider compliance with accepted standards of medical record documentation, metric achievement

5.5.14 Concurrent review for members with special healthcare needs, medically complex cases, and/or adverse outcomes, and children with high health complexity

5.5.15 Delivery System Network report

5.5.16 Subcontractor data reports

5.5.17 Provision of services in accordance with published practice guidelines approved by CHA

5.5.18 Review of member satisfaction surveys, i.e. Consumer Assessment of Healthcare Providers and Systems (CAHPS), Health Outcomes Survey (HOS), Mental Health Statistics Improvement Program (MHSIP), Youth Satisfaction Survey (YSS).

5.5.19 Metrics specific to the utilization of services across sectors as outlined in the *Utilization Measures Review, Analyzation and Remediation* Desktop Process.

5.6 The following platforms and software are used to obtain the data outlined above allowing for further analysis by multiple CHA departments and provider partners:

5.6.1 Internally generated performance reports by the Business Intelligence department provides performance status on all OHA Incentive Metrics at both the enterprise and clinic level.

5.6.2 Externally generated reports from clinic EHRs.

5.6.3 provides population detail via a monthly extract which provides for the identification of subpopulations based on plan/option, number of ER visits, prescriptions, demographics, gender, assigned provider, age, clinical conditions, potentially avoidable cost ranking, and probability of inpatient admit or ER visit.

5.6.4 monthly plan, clinic, and provider scorecards displaying risk score, risk gaps, emergency, inpatient, generic drug utilization, and chronic condition prevalence; data integrity validation conducted annually. Scorecards are used by providers to address specific members with either confirmed or suspected chronic conditions

5.6.5 Maptitude: used to visually identify the physical location of members and providers in CHA's service area to better understand how the geographic distribution of the provider network impacts members and further identify access to care concerns.

5.6.6 Collective Medical (formerly PreManage): population health data to assist in the identification and tracking of ED utilization specific cohorts as well as those with complex chronic conditions to ensure case management services are meeting the needs of the member. Reports are used daily to monitor ED and inpatient utilization.

5.6.7 Reliance eHealth Collaborative (formerly JHIE): population health data including high risk service utilization and SDOH factors, such as homelessness, food insecurity, diabetes, positive pregnancy tests, and hospital visit counts. Data is used to further stratify populations to identify gaps in care, members needing further assistance, and improvement opportunities for both internal processes as well as provider outreach.

5.6.8 Tableau: business intelligence visualization tool used to enhance data reporting representation for internal and external provider reporting for quality metrics, including OHA incentive metrics, access measures, appeals and grievances, member demographics, and member population dispersion. Visualization reports are produced monthly for internal and external distribution through regularly scheduled Committee or internal meetings.

5.6.9 MS SQL: used to retrieve the most current claim information. Queries are developed to validate measures from other sources to produce moment-in-time information. Queries are accessed using SQL Server Reporting Services (SSRS).

5.6.10 Inovalon Care Manager and QSI-XL: used to monitor MA star measures either through direct access to the system or via reports distributed by Atrio.

5.6.11 used to access MA data either through direct access to the system or via reports distributed by Atrio.

5.6.12 Aunt Bertha dba Healthy Klamath Connect (HKC): a community information exchange (CIE) used to connect members to local community resources with the capability to report on the number of searches, users, referrals, and community services. This allows CCC to evaluate the areas of largest need.

5.6.13 Case Management Platform with reporting capabilities to track referrals, prior authorizations, and a variety of services, member demographics, and communications.

5.6.14 Cactus: credentialing database with reporting capabilities that allows us to track provider information (i.e. provider demographics and number of providers by specialty, licenses, insurances, education) and clinic information (i.e. clinic demographics and number of clinics by specialty) for purposes of credentialing, re-credentialing, updating the provider directory, and suppling data for the DSN report.

5.6.15 Programs used for sanction and monitoring activities are described in Credentialing Policy – Appendix 1 PP09002.01

5.6.16 Smartsheets: used for project management and reporting.

5.7 Data reports are analyzed by the Quality Management Department to identify trends and/or concerns, especially as they relate to the quality of care provided to members. Concerns noted are directed to Director directly responsible for the specific service sector for investigation and remediation according to that department's policies, procedures, and processes, including review by the sector's oversight CHA Committee as noted above.

5.8 Minutes are kept of all Committee meeting proceedings and are reviewed annually as part of the annual QAPI Program Evaluation.

Records Management

5.9 Team Members must maintain all records relevant to administering this policy and procedure in the recognized record management system.

6 DEFINITIONS

Terms and Definitions

6.1 **Clean File (Credentialing):** A credentialing or re-credentialing file without discrepancies, red flags, or other concerns regarding the provider's ability to provide services to members.

7 RELATED LEGISLATION AND DOCUMENTS

7.1 *Utilization Measures Review, Analyzation and Remediation PP09007.01*

7.2 42 CFR 438.330

7.3 42 CFR 438.340

7.4 Health Insurance Portability and Accountability Act (HIPAA)

7.5 *HIS.Data.Flow.Diagram*

7.6 Oregon Health Authority (OHA): Coordinated Care Organizations (CCO)

7.7 *QM.Data.Use.PP9005.02*

7.8 *Quality.Metrics.Dashboard.DP9001*

7.9 *Credentialing Policy – Appendix 1 PP09002.01*

8 FEEDBACK

8.1 Team Members may provide feedback about this document by emailing policyfeedback@cascadecomp.com.

9 APPROVAL AND REVIEW DETAILS

Approval and Review	Details
Advisory Committee to Approval	Executive Approval Committee
Committee Review Dates	07/24/2019; 9/5/2019; 10/17/2019; 01/03/2022
Approval Dates	07/31/2019; 9/5/2019; 10/17/2019; 01/03/2022

UTILIZATION MEASURES REVIEW, ANALYZATION, AND REMEDIATION

In this document, CCC is referenced in place of CCC and CHA.

1 PURPOSE

1.1 This document outlines the process for the review of utilization measures, and how the review and analyzation of the data is used to monitor the quality of care provided to CHA members.

2 SCOPE

2.1 This process applies to CHA Medical Management staff, including network providers when issues of concern are identified and require remediation.

3 PROCESS

3.1 CHA tracks a balanced measure set that includes over- and underutilization, access measures, quality measures, medical complexity, and member complaints.

3.2 All measures are reviewed monthly by the appropriate and responsible CHA departments, CHA leadership, and CHA's Quality Management Department to ensure the highest quality care is provided to CHA members.

3.2.1 Identified concerns including poor quality, overutilization or underutilization are referred to the QM department for either root cause analysis, barrier analysis, and/or development of a performance improvement project.

3.2.2 Concerns or negative trends are referred to the responsible department and/or oversight Committee, including the Utilization Review Committee, Quality Management Committee, or Provider Network Committee as applicable, for further analyzation.

3.2.3 Analysis may trigger internal process improvement, including changes to the utilization review process, and/or remediation or corrective action planning with the applicable provider.

3.3 Measures are reported monthly using the following data reference points:

3.3.1 Current performance

3.3.2 Trending year over year comparison

3.3.3 Comparison to national managed Medicaid 50th percentile and OHP 50th percentile Benchmarks.

3.3.4 Cost and units as applicable

3.3.5 Drill down by assigned PCPCH and/or facility.

3.4 The following Utilization Categories and subcategories will be reviewed and analyzed monthly to ensure clinical efficacy and inform improvement work:

3.4.1 Total Cost of Care

3.4.1.1 Physical Health

3.4.1.2 Behavioral Health

3.4.1.3 Oral Health

3.4.2 Inpatient Medical

3.4.2.1 Admissions

3.4.2.2 Inpatient days

3.4.2.3 Average length of stay (LOS)

3.4.3 Inpatient Surgical

3.4.3.1 Admissions

3.4.3.2 Inpatient days

3.4.3.3 Average LOS

3.4.4 Outpatient

3.4.4.1 Hospital

3.4.4.2 Ambulatory surgery

3.4.5 Pharmacy

3.4.6 Professional

3.4.6.1 PCP

3.4.6.2 Specialty

3.4.6.3 Behavioral Health

3.4.7 Laboratory

3.4.8 Imagine

3.4.9 ER Utilization

3.4.9.1 Total

3.4.9.2 Day and time of presentation

3.4.9.3 Acuity

3.4.9.4 Chief Complaint

3.4.9.5 Discharge Diagnosis

3.4.9.6 Assigned PCP

3.4.9.7 Medical ED utilization by members with SPMI

3.4.9.8 SUD Diagnosis (if applicable)

3.4.10 Therapies

3.5 Reports are displayed visually with data points, targets, and benchmarks clearly identified using the sources and platforms identified in Sections 5.5 and 5.6 of the *QAPI Plan PP09007*.

3.5.1 Narratives will accompany those reports that identify concerns or issues requiring further analysis.

QUALITY MANAGEMENT COMMITTEE
CHARTER

I. CHARTER STATEMENT

The Quality Management Committee (QMC) is created and charged by Cascade Health Alliance Board of Directors for the purpose of engaging providers and subcontractors in the service area to provide analysis, assessment, and advisement on the overall quality of services provided by Cascade Health Alliance (CHA), CHA's providers, and subcontractors.

II. PURPOSE:

The purpose of the Quality Management Committee is to:

1. Provide review and oversight of Cascade Health Alliance's Quality Assessment and Performance Improvement (QAPI) and transformation programs, including the Transformation and Quality Strategy (TQS) and CHA's internal Quality Strategy and Work Plan.
2. Analyze data and metrics, including identification of patterns from a quality management or improvement perspective.
3. When opportunities to improve clinical outcomes are noted, the QMC will work with CHA's Chief Medical Officer (CMO) and Director of Quality Management to create strategies to address deficiencies and setting targets for ongoing performance improvement.
4. Review and provide oversight of Grievances related to quality of care concerns, including review of any adverse events impacting CHA members.
5. Provide oversight of performance improvement projects, including:
    a. Reviewing quarterly reports
    b. Recommending topics for new performance improvement projects
    c. Reviewing and approving new performance improvement projects
6. Review and approve CCO policies and procedures related to Quality Management, as needed.
7. Oversee provider credentialing, including the review and reporting of actions taken against providers.
8. Provide oversight of the CCO's Quality Improvement Plan effectiveness in conjunction with CHA'S Utilization Review Committee/Clinical Advisory Panel.
9. Review and approve relevant clinical practice guidelines.
10. Make recommendations to CHA Quality Management and Medical Affairs for action to improve performance and efficiency of CHA.

III. SCOPE:

The QMC will focus on engaging providers and clinics concerning quality management and performance improvement initiatives to ensure that CHA members are receiving high-quality care. QMC serves as an advisory panel to assist CHA in enhancing member experience and achieving the Triple Aim of better care, better health, and reduced cost.

TQS Section 3.A REQUIRED

IV. RESPONSIBILITIES

Responsibilities of QMC include, but are not limited, to the following:

- Help ensure quality initiatives, objectives and goals are being successfully addressed.
- Identify and review quality management issues brought forward by providers, stakeholders or CHA staff.
- Monitor progress on assigned action items, tasks, and projects.

V. MEETINGS

1. Schedule – In order to ensure timely credentialing of providers, QMC meets eight months per year and no less than four times annually.

2. Special Meetings – additional meetings may be called by the QMC Chairperson, CMO, or Director of Quality Management, if necessary, to conduct the business or to address critical issues in a timely manner.

3. Electronic Meeting/Voting – when meeting in person is not possible or advised, the Director of Quality Management will send members emergent items via electronic mail to which their response will be considered their "vote" for purposes of continuing the Committee's work in such situations. Conference calls may also be held when meeting in person is not possible or advised.

4. Cancellation – the CMO or Director of Quality Management may cancel a regularly scheduled meeting if deemed appropriate or if the majority of members are not able to attend the meeting. Cancellation notices will be sent to committee membership via email at least one week prior to meeting.

5. Reminders – meeting reminders will be sent to QMC membership via email the Monday prior to each meeting.

6. Guests – the Chairperson of the QMC, CMO or Director of Quality Management is permitted to invite guests knowledgeable on subjects and issues to any regularly scheduled meeting to support educational aspects and provide expertise when necessary. QMC members are eligible to recommend potential guests at any scheduled meeting.

7. Agendas – meeting agendas shall be developed by the Director of Quality Management or designee. Agendas and meeting materials will be shared with QMC members prior to each meeting for member review.

8. Minutes – meeting minutes shall be developed by the Quality Management Administrative Assistant or other CHA staff as designated by the Director of Quality Management. Minutes of each meeting shall be submitted to the members of the Committee for review prior to

each subsequent meeting. Meeting minutes shall be presented at the next regularly scheduled meeting for approval.

9. Decision Making – a majority of members of the QMC will constitute a quorum. A decision will be approved by simple majority of members in attendance.

10. Confidentiality – QMC members shall be aware of CHA's need for member confidentiality and discretion related to CCO-specific business. The QMC may at times review member-specific data. When possible, CHA will attempt to de-identify member or provider specific information. QMC members shall not report member, provider, or CCO specific information or opinions expressed in meetings outside the Committee, other than to follow-up on a member's clinic-specific business. Certain data and information presented to this Committee are protected by ORS 41.675.

11. Conflict of Interest – it is recognized that QMC members and the organization they represent may be personally, professionally, or financially impacted by the decisions of the Committee. Transparency in sharing conflicts of interest is essential to ensure the integrity of the QMC decision making. QMC members are required to disclose any potential conflicts of interest pursuant to CHA OI 1-05 *Conflict of Interest.*

VI. MEMBERSHIP

1. Composition – the membership of the Committee shall be comprised of (but not limited to) the following:

   At least five, but no more than fifteen, External Parties:
   - Contracted Providers, including at minimum one physical health care provider, one behavioral health care provider, and one dental provider
   - Partner Organization Administration Staff, including Behavioral Health and Dental

   Required CHA staff:
   - Chief Medical Officer (CMO)
   - Director of Quality Management
   - Quality Management staff
   - Additional CHA staff as deemed appropriate

   Additions to External Party membership requires appointment by CHA Board of Director. CHA staff membership must be deemed appropriate by the Director of Quality Management, CMO, or CEO.

2. Term – members shall serve at least one year, with membership reviewed annually.

3. Chairperson – will be selected and confirmed by CHA Board of Directors with recommendations from Committee membership, CEO, CMO, or Director of Quality Management. The term of chairperson is two years.

4. Vice Chairperson – will be selected and confirmed by CHA Board of Directors with recommendations from Committee membership, CEO, CMO, or Director of Quality Management. The term of vice chairperson is two years.

5. Dismissal – members who are absent, without reasonable cause, from at least 50% of regularly scheduled meetings within a calendar year may be excused from the Committee.

6. Vacancies – members of the QMC will be appointed or approved by CHA Board of Directors. When positions are vacated, the QMC, CMO, or Director of Quality Management may either recommend or solicit participation from contracted providers or clinic administration staff.

7. Member Role – members shall:

    - Review and be accountable for their role in the group's efforts.
    - Participate in exercises and be familiar with how the activities of the QMC are relevant to CHA, quality management, and CHA members.
    - Attend QMC meetings consistently or advise of an absence in a timely manner.

VII. ORGANIZATIONAL STRUCTURE

The QMC is an advisory committee to the CHA Board of Directors and is sponsored by CHA. This is a standing and ongoing committee. At least one member of the CHA Board of Directors shall also serve on the QMC.

VIII. SUB COMMITTEES / WORK GROUPS

QMC will charter subcommittees or project teams as needed upon approval from Chief Medical Officer or Director of Quality Management.

IX. CHARTER REVIEW

This QMC charter shall be reviewed annually. Material revisions to the Charter shall be presented to the Board of Directors for approval.

X. CHARTER APPROVAL

Date Chartered: May 3, 2018
Date Approved: August 2, 2018

QUALITY MANAGEMENT COMMITTEE
CHARTER

Date Revised: July 23, 2019
Date Revised: March 23, 2020
Date Approved: April 2, 2020

TQS Section 3.A REQUIRED

QUALITY MANAGEMENT DATA USE POLICY AND PROCEDURE

In this document, CCC may be referenced in place of CCC and/or CHA.

CONTENTS

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

CCC is committed to ensuring all members are provided culturally competent care and services. We provide equal opportunity to members to obtain healthcare that recognizes their experiences, cultural diversity and needs, preferred language, and is inclusive of all protected classes: race, ethnicity, color, National origin, citizenship, religion, sex, sexual orientation, gender, gender identity, marital status, age, physical or mental disability, and veteran status.

Terms not defined in the DEFINITIONS section of this document may be found in the Glossary.

1 PURPOSE

1.1 This policy and procedure establishes an effective framework for managing Quality Management (QM) metrics performance and monitoring data.

1.2 This policy and procedure informs QM team members and other staff of the principles and processes governing the use, analysis, and storage of information related to QM performance and monitoring data.

2 SCOPE

2.1 This policy and procedure applies to all QM team members and any other staff that analyze, collect, use, or manage data related to, but not limited to, Medicaid and Medicare performance, utilization or related data.

2.2 This policy outlines the process for managing and using Medicaid performance data, including clinic data and data shared with providers.

3 POLICY STATEMENT

3.1 Quality Metrics performance data reports are generated internally by the Business Intelligence (BI) department according to OHA metric specifications and any additional referenced metrics specifications (i.e. CMS, HEDIS, etc.)

TQS Section 3.A REQUIRED

3.1.1 BI data analysts run reports to calculate all encounter/claims-based measures as specified by the OHA Incentive Metrics Program.

3.1.2 Benchmarks and targets for each measure are determined by the Metrics and Scoring Committee (MSC) and calculated by OHA for each CCO utilizing the Minnesota Method.

3.1.2.1 New performance measures introduced by the MSC undergo testing and validation by the BI department, and 3rd party vendor, Reliance eHealth.

3.1.3 Reliance eHealth Collaborative and are used as secondary validation and reconciliation sources for internally generated reports.

3.1.3.1 The BI department maintains the shared data between Cascade Health Alliance (CHA) and Reliance eHealth.

3.1.3.2 The BI department maintains the shared data between CHA and

3.2 QM monitors and analyzes performance data relevant to the measures included in OHA's incentive measure program. QM staff utilize the performance dashboards from BI along with the final OHA metric rolling dashboards for measure reporting, and other outputs as needed.

3.3 EHR-based eCQM measures are calculated by clinics' EHRs per specifications provided by OHA and/or CMS and/or Hedis.

3.3.1 QM staff receive Electronic Clinical Quality Measure (eCQM) data from clinics via secure email. ECQM data is analyzed and compiled into plan and clinic-level dashboards collaboratively by BI and QM monthly.

3.3.2 EHR-based data is also available via our Health Information Exchange (HIE), Reliance eHealth Collaborative for all participating providers and facilities. Data includes all OHA and/or CMS measures with access to Community Health Record for specific member data search and summaries.

3.4 QM distributes both claims-based and EHR data reports to CHA leadership and providers monthly.

4 PROCEDURE

4.1 BI staff produce dashboards, trend lines, care gap lists, and other relevant reports for encounter/claims-based and EHR measures. These reports are produced on a monthly basis, and can be produced as requested utilizing the Report Request form.

4.2 The BI staff pulls data monthly and populates plan-level dashboards.

4.2.1 Clinic specific data is pulled and compiled monthly. The data is used to populate clinic specific dashboards and trend lines.

4.3 All dashboards are reviewed monthly by the Chief Medical Officer and the Director of Quality Management, for accuracy prior to distribution to CHA leadership and providers.

4.4 Care gap lists are produced monthly by BI staff and sent to QM staff for filtering and distribution. All relevant lists are shared with clinics monthly via secure email or more frequently as requested.

4.4.1 QM staff filter the plan-level gap lists by provider/clinic and separate into individual Excel workbooks, removing the filter function, to ensure HIPPA compliance.

4.4.2 Special data requests or gap lists cross-walking multiple measures are produced by BI using the Report Request form and process.

TQS Section 3.A REQUIRED

4.5 Data validation for encounter/claims-based measures occurs within the QM and BI departments as well as at the clinic level through analysis and use of dashboards and gap lists. When QM becomes aware of discrepancies or is informed of discrepancies by clinics, QM and BI staff investigate utilizing claims data, Reliance eHealth data, and the Care Coordinator; the OHA dashboard or other member-level claims tools may also be used for reconciliation and validation.

4.5.1 When clinics inform CHA of discrepancies, QM and BI staff utilize Quantum Choice to investigate claims and ensure claims include qualifying CPT and diagnosis codes per the measure specifications. If a non-qualifying code is found, QM staff contact the clinic staff to inform them of the findings.

4.6 Data validation for EHR-based eCQM measures occurs at the clinic or provider organization level through internal processes for validating EHR-based data reporting. Additionally, all EHR-based data submitted to OHA receives validation against a number of potential validity issues, such as: zero denominators, higher than expected denominators or exclusions (compared with national and/or state standards), among others.

4.6.1 QM staff utilize provider assignment lists to validate member enrollment and ensure members are only being counted once per measure.

4.6.2 QM and BI staff validate eCQMs by comparing EHR-based data month-over-month to ensure there is a positive trend and verify denominators and/or numerators are within the expected ranges.

4.6.2.1 If a discrepancy is found, QM and/or BI staff contact the respective clinic staff to discuss findings and remediation.

4.6.3 QM and BI staff may use encounter/claims data to validate visits and services rendered to validate EHR-based measures to verify denominators and/or numerators are within the expected ranges.

5 RESPONSIBILITIES

Compliance, Monitoring and Review

5.1 The QM Department will review this policy and procedure for compliance with applicable state and federal law, OHA contract and guidelines, Information System Capabilities Assessment (ISCA) protocol, and OHA Metrics specifications at least annually, or as applicable. QM will forward the policy to the Executive Review Committee whenever revisions are made.

5.2 QM and BI staff compile data reports monthly, which are shared within the department and to the CMO. Monthly reports include but are not limited to clinic and plan-level dashboards and plan-level trend lines.

5.3 QM is responsible for analyzing CHA and individual clinic performance on the incentive metrics and other identified indicators of performance (i.e. items being tracked in relation to Performance Improvement Projects and the Transformation and Quality Strategy (TQS) on a monthly and/or quarterly basis.

5.3.1 Incentive metrics performance are monitored against targets and benchmarks set by OHA as both a percentage of performance toward the target and trended over time as month over month and year over year.

5.3.2 Based on the analysis of performance, additional data or performance reports may be requested to further understand identified concerns or inform improvement opportunities.

Reporting

5.4 QM reports performance data monthly to provider organizations or upon request.

5.5 QM staff provides care gap lists related to the claims-based measures to each clinic monthly or upon request.

TQS Section 3.A REQUIRED

Records Management

5.6 EHR eCQM data will be maintained in the Quality Management shared drive in the appropriate measurement year sub-folder.

5.7 Encounter/Claims data reports are maintained by the BI department. All finalized dashboards are saved in the QM shared drive in the CHA Dashboard folder within the appropriate measurement year sub-folder.

5.8 Data extracts and reports are sent to Reliance and as well as data reports received from Reliance and are maintained by the BI department.

5.9 Care Gap lists are created by the BI department and emailed to the QM department for separation and distribution. The gap lists are saved in the QM shared drive in the Clinic Engagement folder within the appropriate measurement year sub-folder.

6 DEFINITIONS

Terms and Definitions

6.1 **Electronic Clinical Quality Measure (eCQM):** An EHR-based clinical care quality report included in OHA quality incentive metric program typically following the specifications outlined by CMS.

6.2 **Information System Capabilities Assessment (ISCA):** A bi-annual review conducted by OHA's External Quality Review Organization (EQRO), which involves assessment of all information systems within the CCO, including data systems and use.

7 RELATED LEGISLATION AND DOCUMENTS

7.1 42 Code of Federal Regulations (CFR) §438.358

7.2 42 Code of Federal Regulations (CFR) §438.334(b)

7.3 Health Insurance Portability and Accountability Act (HIPAA)

7.4 OHA External Quality Review Organization (EQRO) Information System Capabilities Assessment (ISCA)

7.5 Oregon Health Authority (OHA) Quality Incentive Metrics Program

8 FEEDBACK

8.1 Team Members may provide feedback about this document by emailing qualitymanagement@cascadecomp.com.

9 APPROVAL AND REVIEW DETAILS

Approval and Review	Details
Advisory Committee to Approval	Executive Review Committee
Committee Review Dates	01/02/2021
Approval Dates	01/23/2021

10 APPENDIX

Quality Metrics Dashboard Process DP09005.01

TQS Section 3.A REQUIRED

QUALITY METRICS DASHBOARD PROCESS

In this document, CCC is referenced in place of CCC and CHA.

1 PURPOSE

1.1 To provide an update on quality metrics performance to internal leadership and clinics.

2 SCOPE

2.1 This process applies to the Quality Management (QM) department.

3 PROCESS

3.1 Data Analysts in the Business Intelligence (BI) Department run the internal reports for metric performance and refresh the dashboard built in Tableau.

3.2 Dashboards are filtered for CHA and every clinic and saved as draft pdfs.

3.3 The CMO, QM Director, and BI Manager meet the first Tuesday of every month to review the draft dashboards and make any necessary edits.

3.4 Once approved, the clinic-level and CHA Quality Metrics dashboards are finalized and shared with the clinics via the monthly Metrics Workgroup meeting.

3.5 The Quality Metrics Dashboards are also distributed at the Quality Management Committee meeting, Behavioral Health Providers meeting, and to Oral Health Providers via email.

TQS Section 3.A REQUIRED

2022 CLAIMS METRICS - All

Cascade Health Alliance

2/28/2023
Danielle Sherman

Max Service Date: 12/31/2022 **Max Recevied Date:** 2/27/2023 **Avg Days:** 31

DISCLAIMER: 2022 measure spec updates and validation continues. 2022 targets have been updated by OHA and reflected here.

Well-Child Visit

55.8%

2022 Target: 60.1%
Benchmark: 64.1%
Num/Denom: 1,058/1,896
Actionable: 0
Gap: 82

Childhood Immz

67.3%

2022 Target: 66.5%
Benchmark: 71.1%
Num/Denom: 276/410
Actionable: 0
Gap: Meeting

Adolescent Immz

38.3%

2022 Target: 36.9%
Benchmark: 36.9%
Num/Denom: 159/415
Actionable: 0
Gap: Meeting

Postpartum Care

87.0%

2022 Target: 80.9%
Benchmark: 80.9%
Num/Denom: 267/307
Actionable: 0
Gap: Meeting

IET Initiation

42.8%

2022 Target: 43.0%
Benchmark: 43.0%
Num/Denom: 180/421
Gap: 2

IET Engagement

14.0%

2022 Target: 13.9%
Benchmark: 13.9%
Num/Denom: 59/421
Gap: Meeting

Initiation and Engagement data not updated

Preventive Dental 1-5

54.2%

2022 Target: 43.1%
Benchmark: 43.1%
Num/Denom: 1,373/2,532
Actionable: 0
Gap: Meeting

Preventive Dental 6-14

61.0%

2022 Target: 48.3%
Benchmark: 52.0%
Num/Denom: 2,750/4,507
Actionable: 0
Gap: Meeting

Oral Evaluation

20.5%

2022 Target: 19.8%
Benchmark: 20.4%
Num/Denom: 246/1,200
Actionable: 0
Gap: Meeting

DHS Assessments

100.0%

2022 Target: 90.0%
Benchmark: 90.0%
Num/Denom: 44/44
Actionable: 0
Gap: Meeting

DHS Physical Health

100.0%

Num/Denom: 44/44
Actionable: 0

1/3 of Assessments

DHS Dental Health

100.0%

Num/Denom: 33/33
Actionable: 0

1/3 of Assessments

DHS Mental Health

100.0%

Num/Denom: 21/21
Actionable: 0

1/3 of Assessments

Data Sources:
ALERT IIS, Reliance
nd CHA Case Mgt
-Allow for 1-4 months claims lag

Challenge Pool Measures:
Well-Child, IET Init and Eng, DHS, and Adolescent Immz

Red: Likely will not meet
Yellow: May meet
Green: Currently Meeting

TQS Section 3.A REQUIRED

HEALTH PROMOTION AND PREVENTION

POLICY AND PROCEDURE

In this document, CCC is referenced in place of CCC and CHA.

CONTENTS

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Terms not defined in the DEFINITIONS section of this document may be found in the Glossary.

1 PURPOSE

1.1 This policy establishes Cascade Health Alliance (CHA) expectations of providers in promoting and performing health screenings to aid in the prevention of chronic illness.

2 SCOPE

2.1 This policy applies to all providers, including physical, behavioral and oral health care providers.

3 POLICY STATEMENT

3.1 CCC expects providers to actively promote all health screening methodologies which have received a Grade A or B recommendation by the United States Preventive Services Task Force to all members and their families.

3.2 For those providers serving pediatric members, CCC expects the active promotion of screenings recommended by Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents (4th Edition; 2017).

4 PROCEDURE

4.1 Providers will establish internal, individual clinic processes and workflows to ensure that the recommended health screenings are performed as appropriate for each member.

4.2 The Quality Management (QM) Department will establish an annual plan for Health Promotion and Prevention activities as part of its annual strategic planning process.

5 RESPONSIBILITIES

TQS Section 3.A REQUIRED

Compliance, Monitoring and Review

5.1 CHA's QM Department will monitor and review providers' use of health screenings through the monitoring and review of outcome data, member satisfaction, and service utilization.

5.2 CHA's QM Committee reviews performance data on a quarterly basis at minimum.

5.3 The Executive Approval Committee will review this policy and procedure for compliance with OHA contract and guidelines at least once a year, or as applicable.

5.4 This policy aligns with the expectations set forth in CCC's contract with the Oregon Health Authority to provide services as a Health Plan.

Reporting

5.5 The Quality Management Committee's recommendations as they pertain to Health Promotion and Prevention will be reported in the annual Quality Assurance and Performance Improvement (QAPI) Evaluation.

5.6 The activities of the QM Department as they pertain to Health Promotion and Prevention within the broader community as well as member specific efforts will be reported in the annual QAPI Evaluation.

Records Management

5.7 Team Members must maintain all records relevant to administering this policy and procedure in the recognized record management system.

6 DEFINITIONS

6.1 There are no terms or definitions to define for the administration of this policy.

7 RELATED LEGISLATION AND DOCUMENTS

7.1 Quality Assurance and Performance Improvement Policy PP09007

7.2 United States Preventive Services Task Force: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

7.3 Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents (4th Edition; 2017): https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_Introduction.pdf

7.4 Health Insurance Portability and Accountability Act (HIPAA)

7.5 Oregon Health Authority (OHA): Coordinated Care Organizations (CCO)

8 FEEDBACK

8.1 Team Members may provide feedback about this document by emailing policyfeedback@cascadecomp.com.

9 APPROVAL AND REVIEW DETAILS

Approval and Review	Details
Advisory Committee to Approval	Quality Management Committee
Committee Review Dates	09/02/2021
Approval Dates	09/02/2021

10 Appendices

TQS Section 3.A REQUIRED

10.1 *Screening of High Risk and Prioritized Populations for Opioid Use Disorders PP09006.01*

TQS Section 3.A REQUIRED

Screening of High Risk and Prioritized Populations for Opioid Use Disorders

In this document, CCC is referenced in place of CCC and CHA.

1 PURPOSE

1.1 The purpose of this document is to outline the expectations for the screening of high risk and prioritized populations for Opioid Use Disorders to facilitate prevention and treatment services.

2 SCOPE

2.1 This applies to all CHA members and contracted providers.

3 Process

3.1 High Risk and Prioritized Populations are those populations considered at high risk for severe health outcomes, including overdose and death:

- 3.1.1 Pregnant women
- 3.1.2 Veterans and their families
- 3.1.3 Women with children
- 3.1.4 Unpaid caregivers
- 3.1.5 Families
- 3.1.6 Children ages birth through five years
- 3.1.7 Children in Foster Care or under the custody of DHS
- 3.1.8 Individuals at the risk of first episode of psychosis
- 3.1.9 IV drug users
- 3.1.10 Individuals with HIV/AIDS or tuberculosis
- 3.1.11 Individuals with Intellectual and/or Developmental Disabilities (I/DD)
- 3.1.12 Individuals being discharged from residential, acute care, and other institutional settings
- 3.1.13 Children with serious emotional disturbance
- 3.1.14 Members with Opioid Use Disorder
- 3.1.15 Individuals requiring Medication Assisted Treatment
- 3.1.16 Members eligible for ICC Services

3.2 High Risk and Prioritized Populations must be screened for Opioid Use Disorders under the following circumstances to provide prevention services, early detection, brief intervention and referral to behavioral health services:

- 3.2.1 At initial contact or during a routine physical exam
- 3.2.2 At an initial prenatal exam

TQS Section 3.A REQUIRED

3.2.3 When the member shows evidence of SUD or abuse

3.2.4 When the member over-utilizes covered services, and/or

3.2.5 When a member exhibits a reassessment trigger for Intensive Care Coordination

3.3 Pregnant members receiving prenatal and post-partum care will be screened using validated tools for behavioral health needs at least once during pregnancy and once during the post-partum period.

3.4 Members with positive screens will be referred for further preventive or treatment services as indicated by the outcome of the screening as deemed appropriate by the provider conducting the screening.

3.4.1 Intake and access timeliness for pregnant women and other priority populations shall be in accordance with 410-141-3220.20

4 Related Documents and Legislation

4.1 Oregon Administrative Rule 410-141-3220

4.2 Oregon Health Authority Contract #161756

TQS Section 3.A REQUIRED

Screening of High Risk and Prioritized Populations for Opioid Use Disorders

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TQS Section 3.A REQUIRED

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4.2 Oregon Health Authority Contract #161756

TQS Section 3.A REQUIRED

QUALITY MANAGEMENT COMMITTEE
CHARTER

I. CHARTER STATEMENT

The Quality Management Committee (QMC) is created and charged by Cascade Health Alliance Board of Directors for the purpose of engaging providers and subcontractors in the service area to provide analysis, assessment, and advisement on the overall quality of services provided by Cascade Health Alliance (CHA), CHA's providers, and subcontractors.

II. PURPOSE:

The purpose of the Quality Management Committee is to:

1. Provide review and oversight of Cascade Health Alliance's Quality Assessment and Performance Improvement (QAPI) and transformation programs, including the Transformation and Quality Strategy (TQS) and CHA's internal Quality Strategy and Work Plan.
2. Analyze data and metrics, including identification of patterns from a quality management or improvement perspective.
3. When opportunities to improve clinical outcomes are noted, the QMC will work with CHA's Chief Medical Officer (CMO) and Director of Quality Management to create strategies to address deficiencies and setting targets for ongoing performance improvement.
4. Review and provide oversight of Grievances related to quality of care concerns, including review of any adverse events impacting CHA members.
5. Provide oversight of performance improvement projects, including:
    a. Reviewing quarterly reports
    b. Recommending topics for new performance improvement projects
    c. Reviewing and approving new performance improvement projects
6. Review and approve CCO policies and procedures related to Quality Management, as needed.
7. Oversee provider credentialing, including the review and reporting of actions taken against providers.
8. Provide oversight of the CCO's Quality Improvement Plan effectiveness in conjunction with CHA'S Utilization Review Committee/Clinical Advisory Panel.
9. Review and approve relevant clinical practice guidelines.
10. Make recommendations to CHA Quality Management and Medical Affairs for action to improve performance and efficiency of CHA.

III. SCOPE:

The QMC will focus on engaging providers and clinics concerning quality management and performance improvement initiatives to ensure that CHA members are receiving high-quality care. QMC serves as an advisory panel to assist CHA in enhancing member experience and achieving the Triple Aim of better care, better health, and reduced cost.

TQS Section 3.A REQUIRED

IV. RESPONSIBILITIES

Responsibilities of QMC include, but are not limited, to the following:

- Help ensure quality initiatives, objectives and goals are being successfully addressed.
- Identify and review quality management issues brought forward by providers, stakeholders or CHA staff.
- Monitor progress on assigned action items, tasks, and projects.

V. MEETINGS

1. Schedule – In order to ensure timely credentialing of providers, QMC meets eight months per year and no less than four times annually.

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each subsequent meeting. Meeting minutes shall be presented at the next regularly scheduled meeting for approval.

9. Decision Making – a majority of members of the QMC will constitute a quorum. A decision will be approved by simple majority of members in attendance.

10. Confidentiality – QMC members shall be aware of CHA's need for member confidentiality and discretion related to CCO-specific business. The QMC may at times review member-specific data. When possible, CHA will attempt to de-identify member or provider specific information. QMC members shall not report member, provider, or CCO specific information or opinions expressed in meetings outside the Committee, other than to follow-up on a member's clinic-specific business. Certain data and information presented to this Committee are protected by ORS 41.675.

11. Conflict of Interest – it is recognized that QMC members and the organization they represent may be personally, professionally, or financially impacted by the decisions of the Committee. Transparency in sharing conflicts of interest is essential to ensure the integrity of the QMC decision making. QMC members are required to disclose any potential conflicts of interest pursuant to CHA OI 1-05 *Conflict of Interest.*

VI. MEMBERSHIP

1. Composition – the membership of the Committee shall be comprised of (but not limited to) the following:

   At least five, but no more than fifteen, External Parties:
   - Contracted Providers, including at minimum one physical health care provider, one behavioral health care provider, and one dental provider
   - Partner Organization Administration Staff, including Behavioral Health and Dental

   Required CHA staff:
   - Chief Medical Officer (CMO)
   - Director of Quality Management
   - Quality Management staff
   - Additional CHA staff as deemed appropriate

   Additions to External Party membership requires appointment by CHA Board of Director. CHA staff membership must be deemed appropriate by the Director of Quality Management, CMO, or CEO.

2. Term – members shall serve at least one year, with membership reviewed annually.

3. Chairperson – will be selected and confirmed by CHA Board of Directors with recommendations from Committee membership, CEO, CMO, or Director of Quality Management. The term of chairperson is two years.

4. Vice Chairperson – will be selected and confirmed by CHA Board of Directors with recommendations from Committee membership, CEO, CMO, or Director of Quality Management. The term of vice chairperson is two years.

5. Dismissal – members who are absent, without reasonable cause, from at least 50% of regularly scheduled meetings within a calendar year may be excused from the Committee.

6. Vacancies – members of the QMC will be appointed or approved by CHA Board of Directors. When positions are vacated, the QMC, CMO, or Director of Quality Management may either recommend or solicit participation from contracted providers or clinic administration staff.

7. Member Role – members shall:

    - Review and be accountable for their role in the group's efforts.
    - Participate in exercises and be familiar with how the activities of the QMC are relevant to CHA, quality management, and CHA members.
    - Attend QMC meetings consistently or advise of an absence in a timely manner.

VII. ORGANIZATIONAL STRUCTURE

The QMC is an advisory committee to the CHA Board of Directors and is sponsored by CHA. This is a standing and ongoing committee. At least one member of the CHA Board of Directors shall also serve on the QMC.

VIII. SUB COMMITTEES / WORK GROUPS

QMC will charter subcommittees or project teams as needed upon approval from Chief Medical Officer or Director of Quality Management.

IX. CHARTER REVIEW

This QMC charter shall be reviewed annually. Material revisions to the Charter shall be presented to the Board of Directors for approval.

X. CHARTER APPROVAL

Date Chartered: May 3, 2018
Date Approved: August 2, 2018

QUALITY MANAGEMENT COMMITTEE
CHARTER

Date Revised: July 23, 2019
Date Revised: March 23, 2020
Date Approved: April 2, 2020

TQS Section 3.A REQUIRED

QMC Meeting – February 2, 2023
CHA Boardroom/ RingCentral

Present: David Shute, MD (CMO); Nora Foster, QMHP-C; Stanton Smith, MD (arrived at 7:40am); Hannah Hayes, PA; Aaron Davis, DMD; Jordan Hoese, MD (meeting feedback provided via email); David Elliott; Jeff Dover, JD; Chanel Smith; Shelley Emary; Sherrie Ardolino; Tayo Akins

Absent : Michol Polson, PhD ; Michael Donarski

Motion to approve minutes from December 1, 2022
- **Motion – Nora**
- **Second – Hannah Hayes PA**
- **All approved**

Sanction Monitoring Activities Reviewed: Q4 + November 2022 – No new findings.

Reviewed Credentialing Files: December
- **Adam Aufderheide, MD**
  - **Motion – Hannah Hayes PA**
  - **Second – Nora Foster QMHP-C**
  - **All Approved -6/1/23 had extended approval. Case was dismissed. Motion to move to a permanent approval through the end of the term ending 12/3/23**
- **Shawn Spalding MD**
  - **Motion – Nora Foster QMHP-C**
  - **Second – Aaron Davis DMD**
  - **All approved**
- **Kayla Culp, NP**
  - **Motion – Nora Foster QMHP-C**
  - **Second – Hannah Hayes PA**
  - **All approved**
- **Ryan Dutton, PA**
  - **Motion – Nora Foster QMHP-C**
  - **Second – Hannah Hayes PA**
  - **All approved**
- **Lane Robinson, MD**
  - **Motion – Hannah Hayes PA**
  - **Second – Aaron Davis DMD**
  - **All Approved**
- **David Coker, QMHP**
  - **Motion – Nora Foster QMHP-C**
  - **Second – Hannah Hayes PA**
  - **All approved**

CMO-Approved prior to Committee (3 years):

- (R) Michael Casey MD (3yrs)
- (I) Melissa KIDBY PMHNP (3yrs)
- (I) Todd Raudy MD (3yrs)
- (I) Rachel McCoy MD (3yrs)
- (I) Angela Kehrley NO (3yrs)
- (R) Julie Lee FNP (3yrs)
- (I) Emily Vazquez LCSW (3yrs)
- (R) Toeney Flowers LCSW (3yrs)
- (R) Charla Wade LCSW (3yrs)
- (I) Jordan Hoese MD (3yrs)
- (R) Eric Brunswisk MD (3yrs)
- (I) Anna Sokolowski MD (3yrs)
- (I) Nimota Bello DNP (3yrs)
- (R) Margaret Jolley MD (3yrs)
- (I) Joel Klas MD (3yrs)
- (I) Kristi Coleman MD (3yrs)
- (R) Mark McClure LPC (3yrs)

Quality Measure Dashboards:

- CHA 2022 Status – Missing 2 of the Challenge pools- MLA and Child and Adolescent Well Care visit. Strategizing internally to work with Quality Metrics Workgroup to ensure future success. Currently meeting 11 of the 14 measures. Issues with Reliance data so IET measure is not reflecting current reporting for the measure. Passing all the EHR metrics. Based on current performance, CHA will earn 100% of the 2022 incentive metric pool.
- ATRIO 2022 Status – Will be getting updates for performance monthly. Trying to get practice level data and performance.

Compliance Monitoring Review:

- Jeff Dover presented the results of the 2022 EQR audit. CHA met 5 of the 8 elements for CMR Compliance. Goal is to meet all 8 elements. Improvement plan is being implemented for the partially met 3 measures.
- CHA exceeded the average statewide CCO EQR score.
- No strengths were identified for the QAPI standard. Need to revise aspects of it to meet the federal and state requirements but information was generalized so CHA is working through the specifics to turn the partially met measures into fully met.
- Develop a QAPI workplan for 2023 by March QMC meeting.
- LTSS – monitor mechanisms within the MOU
- QMC – standardize a schedule to capture discussion and activities.
    - Not enough detail overseeing subcommittees
- Need to demonstrate compliance by explaining quality assessment and performance improvement plans that entails improvement activities and proper oversight.

Credentialing Discussion:

- Foreign Graduates – Jeff Dover presented the challenge that with foreign dental graduates, CHA may not be unable to obtain primary source verification and sought committee guidance on how to proceed in these instances.
- Jeff also sought input regarding credentialing of providers that don't have BLS or ACLS certification and or hospital privileges.

Committee Membership Updates:

- Paul Stewart has retired and is no longer a member.

- David Cauble, CEO at Sky Lakes Medical Center, will be replacing him soon.

Adjourned: 8:00AM

Respectfully Submitted:

Dr. David Shute CMO QMC Interim Chair	Sherrie Ardolino Quality Transformation Coordinator

Cascade Health Alliance, LLC

QMC Meeting – April 7, 2022 – 0700
RingCentral

Present: David Shute, MD (CMO); Nora Foster, QMHP-C; Hannah Hayes, PA; Aaron Davis, DMD; Paul Stewart; Stanton Smith MD; Shelley Emary; Patricia Pahl; David Elliott; Chanel Smith; Jeff Dover, JD; Gita Yitta, DMD

Absent: Tayo Akins; Jordan Hoese, MD; Michol Polson, PhD; Michael Donarski (COO)

Motion to approve minutes from February 03, 2022.

- **Motion – Nora Foster, QMHP-C**
- **Second – Paul Stewart**
- **All Approved**

Sanction Monitoring Activities Reviewed: February 2022; Q2 2022 – No new findings.

Credentialing Discussion:
Reviewed Credentialing Files: February and March 2022

- **William Krause, MD**
  - **Tabled from last meeting pending additional information. No additional information provided.**
  - **Motion – Paul Stewart**
  - **Second – Hannah Hayes, PA?**
  - **All Approved (3 years)**
- **Sadridden Naimov, DMD**
  - **Motion – Hannah Hayes, PA**
  - **Second – Nora Foster, QMHP-C**
  - **All Approved (Remainder of 3 years; add 2 years to 1 year approved in 2021)**
- **Roger Piepenbrink, DO**
  - **Motion – Paul Stewart**
  - **Second – Nora Foster, QMHP-C**
  - **All Approved (3 years)**
- **MaryLou Alonso, NP**
  - **Motion – Hannah Hayes, PA**
  - **Second – Nora Foster, QMHP-C**
  - **All Approved (3 years)**
- **Alice Elroy, MD**
  - **Motion – Hannah Hayes, PA**
  - **Second – Nora Foster, QMHP-C**
  - **All Approved (3 years)**
- **Alex Peterson, DO**
  - **Motion – Hannah Hayes, PA**
  - **Second – Nora Foster, QMHP-C**
  - **All Approved (3 years)**

Jeff notified CCC received an appeal from Scott Wallace, DC for credentialing application denial and explained there will be a hearing.

Dr. Shute let committee know Charles Dodds, MD with M2 Anesthesia opted to withdraw credentialing application.

CMO-Approved prior to Committee (3 years):

- (I) Donald DeFrang, PA-C (3 yrs.)
- (I) Timothy Ullesett, PA-C (3 yrs.)
- (R) Matthew Heberling, PA-C (3 yrs.)
- (R) Jennifer Patzke, LPC (3 yrs.)
- (R) Nellie Wirsing, MD (3 yrs.)
- (I) Chris Roberts, PMNHP (3 yrs.)
- (I) Hyung Chil Kang, MD (3 yrs.)
- (R) Scott Stevens, MD (3 yrs.)
- (I) Tricia Shugart, FNP (3 yrs.) ATRIO only
- (R) Juanita Waites, PsyD (3 yrs.)
- (R) Peter Erickson, LPC (3 yrs.)

Dental: Clinical Practice Guidelines

- Dr. Yitta presented guidelines. Dr. David agreed with guidelines chosen.
- **Motion – Paul Stewart**
- **Second – Hannah Hayes, PA**
- **All Approved**

Transformation and Quality Strategy (TQS):

- Patricia and David Elliott gave a high-level overview using TQS summaries about the 2022 TQS projects and let the committee know TQS was submitted to OHA.
- **Motion – Paul Stewart**
- **Second – Nora Foster, QMHP-C**
- **All Approved**

Quality Measure Dashboards:

- ATRIO Stars
  - Patricia gave a high-level overview.
- CHA
  - David Elliott gave a high-level overview.

Performance Improvement Projects (PIPs):

- David Elliott and Patricia provide status updates for Mental Health Services Access Monitoring (State PIP), IET, PCPCH, and SDOH

Adjourned: 0755

Respectfully Submitted:

Dr. David Shute, CMO QMC Interim Chair Patricia Pahl, Quality Management Analyst

Cascade Health Alliance, LLC

QMC Meeting – May 5, 2022 – 0700
RingCentral

Present: David Shute, MD (CMO); Nora Foster, QMHP-C; Aaron Davis, DMD; Paul Stewart; Stanton Smith MD; Shelley Emary; Patricia Pahl; David Elliott; Jeff Dover, JD; Michael Donarski (COO); Scott Wallace, DC (during the hearing portion)

Absent: Tayo Akins; Jordan Hoese, MD; Michol Polson, PhD; Hannah Hayes, PA; Chanel Smith

Approval of minutes from April 7, 2022 will occur at next meeting.

Sanction Monitoring Activities Reviewed: No new sanction monitoring to report as OIG/SAM exclusion lists not yet updated for May. Will be presented next month.

Credentialing Discussion:
Scott Wallace Appeal Hearing; Tabled and meet tomorrow (May 6th) at 7am

Reviewed Credentialing Files: April 2022

- **Patrick Story, LMFT**
  - **Motion – Nora Foster, QMHP-C**
  - **Second – Paul Stewart**
  - **All Approved (3 years)**
- **Jennifer Wheeler, LCSW**
  - **Motion – Nora Foster, QMHP-C**
  - **Second – Paul Stewart**
  - **All Approved (3 years)**
- **Brooke Keffer, EPDH**
  - **Motion – Stanton Smith, MD**
  - **Second – Nora Foster, QMHP-C**
  - **All Approved (3 years)**
- **Eric Svendsen, PA-C; Alia Ashraf, DO; Erin Gonzales, MD; and Slavka Kucinska, MD**
  - **Motion – Paul Stewart**
  - **Second – Stanton Smith, MD**
  - **All Approved (3 years)**

CMO-Approved prior to Committee (3 years): List will be shared at next meeting.

Quality Measure Dashboards:

- ATRIO Stars
  - Patricia gave a high-level overview of Stars strategy and interventions.
- CHA
  - David Elliott gave a high-level overview of dashboard.

Performance Improvement Projects (PIPs):

- David Elliott and Patricia provide status updates for Mental Health Services Access Monitoring (State PIP), IET, PCPCH, and SDOH
  - Patricia gave a high-level overview about each PIP.

Adjourned: 0800

Respectfully Submitted:

Dr. David Shute, CMO	QMC Interim Chair	Patricia Pahl, Quality Management Analyst

Cascade Health Alliance, LLC

QMC Meeting – August 4, 2022 – 0706
RingCentral

Present: David Shute, MD (CMO); Nora Foster, QMHP-C; Aaron Davis, DMD; Michol Polson, PhD; Shelley Emary; Patricia Pahl; David Elliott; Jeff Dover, JD; Chanel Smith

Email Vote: Hannah Hayes, PA; Paul Stewart

Absent: Tayo Akins; Jordan Hoese, MD; Stanton Smith MD

Motion to approve minutes from April 07, 2022, and May 05, 2022. – Tabled for next meeting

Sanction Monitoring Activities Reviewed: May, June 2022 – No new findings.

Reviewed Credentialing Files: May, June, July 2022

- **Adam Aufderheide, MD (status update)**
  - **Motion – Aaron Davis, DMD**
  - **Second – Nora Foster, QMHP-C**
  - **Approved to extend temp credential for one year. Will bring back to committee in one year or sooner if information to have is available.**
    - **Two votes in person, two votes via email**
- **Michael Duffin, MD; Patrick Hagerty, DMD; Deepika Wali, MD; Edward Van Tassel, DO; Teresa Graham, MD**
  - **Motion – Nora Foster, QMHP-C**
  - **Second – Aaron Davis, DMD**
  - **All approved (3 years)**
    - **Two votes in person, two votes via email**
- **Clayton Augustine, PCA-R**
  - **Tabled for next meeting**

Michael Sheets, NP – Update provided to committee.

August Meeting

CMO-Approved prior to Committee (3 years):

- (R) Scott Potenta, MD (3 yrs.)
- (R) Kyle Dearing, OD (3 yrs.)
- (I) James Muntz, PA-C (3 yrs.)
- (I) Amr Hassan, MD (3 yrs.)
- (I) Tessa Saindron, LPC (3 yrs.)
- (R) Jeffrey Merrill, DPM (3 yrs.)
- (R) David Souza, DO (3 yrs.)
- (I) Jennifer Fleischer, MD (3 yrs.)
- (R) William West, AuD PhD (3 yrs.)
- (I) William Wingard, PCAR (3 yrs.)
- (R) Robert Jackman, MD (3 yrs.)
- (R) Charlotte Rohrbacker, LCSW (3 yrs.)
- (I) Katherine Heinrich, NP (3 yrs.)
- (I) Brian Summers, DMD (3 yrs.)
- (I) Brea Frost, PA-C (3 yrs.)

Follow-up from May Meeting

CMO-Approved prior to Committee (3 years): List was not shared at May or August meeting. To know who were credentialed in February, March, and April 2022, refer to credentialing tracking files.

Quality Measure Dashboards:

- CHA
  - David Elliott shared news about OHA Incentive Metrics 2021 final results. He gave a high-level overview of current dashboard. Dr. Shute called attention to the dental measures.
- ATRIO Stars
  - Team gave an update on current initiatives, and Chanel gave update on dashboard.

OHA Feedback on 2021 TQS:

- Chanel gave update on what TQS is and OHA feedback.

Adjourned: August 11, 2022 at 3:40 PM (Meeting was left open to allow for voting by email.)

Respectfully Submitted:

Dr. David Shute, CMO	QMC Interim Chair	Patricia Pahl, Quality Management Analyst

Cascade Health Alliance, LLC

QMC Meeting – September 15, 2022 – 0704
RingCentral

Present: David Shute, MD (CMO); Nora Foster, QMHP-C; Aaron Davis, DMD; Jordan Hoese, MD; Stanton Smith, MD; Shelley Emary; Patricia Pahl; David Elliott; Jeff Dover, JD

Absent: Tayo Akins; Hannah Hayes, PA; Michol Polson, PhD; Paul Stewart; Chanel Smith

This meeting was initially scheduled for September 1, 2022.
Since there was not a quorum, meeting was rescheduled.

Motion to approve minutes from April 07, 2022, May 05, 2022, and August 4 2022.
- **Motion – Nora Foster, QMHP-C**
- **Second – Aaron Davis, DMD**
- **All approved**

Sanction Monitoring Activities Reviewed: July 2022 – No new findings.

Reviewed Credentialing Files: August 2022
- **Tracy Graham, MD**
  - **Motion – Nora Foster, QMHP-C**
  - **Second – Jordan Hoese, MD**
  - **All approved (3 years)**
- **Clayton Augustine, PCA-R**
  - **Motion – Aaron Davis, DMD**
  - **Second – Jordan Hoese, MD**
  - **All approved (1 year)**
    - **Reassess after a year. Obtain new peer reviews at that time.**
    - **Nora Foster, QMHP-C recused self from vote.**
- **Joann Eiman, PA**
  - **Motion – Nora Foster, QMHP-C**
  - **Second – Aaron Davis, DMD**
  - **All approved (3 years)**

September Meeting

CMO-Approved prior to Committee (3 years):

- (R) Monna Alwine, AGNP (3 yrs.)
- (I) Nafeeshathul Riyaj-Ahamed, MD (3 yrs.)
- (I) Jean McCalmont, FNP (3 yrs.)
- (I) Kathleen Adams, LMFT (3 yrs.)
- (R) Susan Barnes, MD (3 yrs.)
- (I) Peter Gonzalez, DDS (3 yrs.)

Quality Measure Dashboards:
- Final CCO Incentive Results – Dr. Shute gave update on final 2021 performance.
- CHA 2022 Quality Metric Status – Dr. Shute gave update on current status.

PIP Quarterly Summaries:
- Patricia gave summary on SDOH and PCPCH PIPs, and David Elliott gave summary on IET PIP.

Adjourned: 7:40 AM

Respectfully Submitted:

Dr. David Shute, CMO QMC Interim Chair	Patricia Pahl, Quality Management Analyst

Cascade Health Alliance, LLC

QMC Meeting – October 6, 2022 – 0700
RingCentral

Present: David Shute, MD (CMO); Nora Foster, QMHP-C; Aaron Davis, DMD; Stanton Smith, MD; Jordan Hoese, MD; Patricia Pahl; David Elliott; Jeff Dover, JD; Chanel Smith

Absent: Tayo Akins; Michol Polson, PhD; Hannah Hayes, PA; Paul Stewart; Shelley Emary

Motion to approve minutes from September 15, 2022
- **Motion – Nora Foster, QMHP-C**
- **Second – Jordan Hoese, MD**
- **All approved**

Sanction Monitoring Activities Reviewed: August 2022 – No new findings.

Reviewed Credentialing Files: September 2022
- **Bretton Breazeale, MD; Leonard Brennan, LPC; Joanna Narkiewicz-Jodko, MD**
  - **Motion – Nora Foster, QMHP-C**
  - **Second – Aaron Davis, DMD**
  - **All approved (3 years)**
- **Shelly Thorpe, NP**
  - **Motion – Aaron Davis, DMD**
  - **Second – Stanton Smith, MD**
  - **All approved (3 years)**
- **Sharon Cowie, FNP**
  - **Motion – Stanton Smith, MD**
  - **Second – Aaron Davis, DMD**
  - **All approved (3 years)**
- **Lisa Pearson, MD**
  - **Motion – Stanton Smith, MD**
  - **Second – Aaron Davis, DMD**
  - **All approved (3 years)**
- **Kevin Heaton, DO**
  - **Motion – Stanton Smith, MD**
  - **Second – Aaron Davis, DMD**
  - **All approved (3 years)**

CMO-Approved prior to Committee (3 years):

- (R) Jan Hallock, DO (3 yrs.)

Quality Measure Dashboards:
- CHA 2022 Status – David Elliott gave update on current status.
- ATRIO 2022 Status – Patricia gave update on current status.

Clinical Guidelines
-

- Additional medical guidelines, U.S. Preventive Services Task Force (USPSTF) and Bright Future (Pediatrics), will be included in committee review and vote as well.

- Dental (previously reviewed in April)

Adjourned: 7:37 AM

Respectfully Submitted:

Dr. David Shute, CMO QMC Interim Chair	Patricia Pahl, Health Equity Manager

Cascade Health Alliance, LLC

QMC Meeting – December 1, 2022 – 0703
RingCentral

Present: David Shute, MD (CMO); Nora Foster, QMHP-C; Stanton Smith, MD; Paul Stewart; Hannah Hayes, PA; Aaron Davis, DMD; Patricia Pahl; David Elliott; Jeff Dover, JD; Chanel Smith; Shelley Emary; Michael Donarski; Sherrie Ardolino; Tayo Akins

Absent: Michol Polson, PhD; Jordan Hoese, MD

Motion to approve minutes from October 6, 2022
- **Motion – Paul Stewart**
- **Second – Nora Foster, QMHP-C**
- **All approved**

Sanction Monitoring Activities Reviewed: Q3 2022 + October 2022 – No new findings.

Reviewed Credentialing Files: October and November 2022

- **Adam Aufderheide, MD**
  - **Motion – Paul Stewart**
  - **Second - Hannah Hayes, PA**
  - **All Approved – Additional six (6) month extension.**
    - **Provider being monitored and new hearing on Jan 19th.**
    - **Previous extension ended today. Renewal due in twelve (12) months.**
- **Jennifer Archibald, PA**
  - **Motion – Stanton Smith, MD**
  - **Second – Paul Stewart**
  - **All approved (3 years)**
- **Xinming Wu, MD**
  - **Motion – Paul Stewart**
  - **Second – Hannah Hayes, PA**
  - **All approved (3 years)**
- **Ami Patel, MD**
  - **Motion – Hannah Hayes, PA**
  - **Second – Aaron Davis, DMD**
  - **All approved (3 years)**
- **Ryan Dutton, PA – Table for a E-vote upon receipt of additional references.**
- **Mark Reed, FNP**
  - **Motion – Aaron Davis, DMD**
  - **Second – Hannah Hayes, PA**
  - **All approved (3 years)**
- **George Wang, MD**
  - **Motion – Stanton Smith, MD**
  - **Second – Paul Stewart**
  - **All approved (3 years)**
- **Sanjay Jain, MD**
  - **Motion – Stanton Smith, MD**
  - **Second – Paul Stewart**
  - **All approved (3 years)**

- **CMO-Approved prior to Committee (3 years):**
  - (I) Adam Anson (3yrs)
  - (I) Michele Medina (3yrs)
  - (R) Joyce Hollander-Rodriguez (3yrs)
  - (I) Joshua Dworkin (3yrs)
  - (I) Amanda Kirby (3 yrs)
  - (R) Jay Williams (3yrs)
  - (I) Angela Mason (3yrs)
  - (R)Nathan Miller (3yrs)
  - (I) Brandon Snowdy (3yrs)
  - (I) Amanda Morgenthal (3yrs)
  - (I) Kirsten Balin (3yrs)
  - (I) Saige Kubac (3yrs)
  - (I) Kevin Scheppke (3yrs)
  - (R) Jakob Freid (3yrs)
  - (R) Eric Smith (3yrs)
  - (I) Kieran Kubac (3yrs)

Quality Measure Dashboards:

- CHA 2022 Status – David Elliott gave update on metrics by categorizing each metric as met, likely to meet, needs attention, and likely to not meet.
- ATRIO 2022 Status – No Update

CHA 2023 TQS Planning:

- David Elliott provided high level overview of Transformation Quality Strategy (TQS).
- Medical Dental Integration Project
  - David Elliott gave high level overview of current project and thoughts of QM staff. Then, he requested input from committee members.
  - Committee Feedback
    - Dr. Davis: Klamath Health Partnership (KHP) strives to do more and refers patients between two departments they have. Does not have any recommendations for CHA.
- Cultural and Linguistic Services Provision
  - David Elliott gave high level overview of current project and thoughts of QM staff. Then, he requested input from committee members.
  - No Committee Feedback

Clinical Guidelines

- Clinical [Medical] Practice Guidelines
  - Previously reviewed in October.
  - Motion – Paul Stewart
  - Second – Hannah Hayes, PA
  - All approved (3 years)
- Behavioral Health Guidelines
  - Previously reviewed in October.
  - Motion – Paul Stewart
  - Second – Aaron Davis, DMD

  - All approved (3 years)
- Dental Guidelines –
  - ADA and CDC guidelines. Approved by committee earlier this year. These were re-approved this meeting so their approval schedule with the rest of the guidelines.
  - Motion – Aaron Davis, DMD
  - Second – Nora Foster, QMHP-C
  - All approved (3 years)

Adjourned: 7:56AM

Respectfully Submitted:

Dr. David Shute, CMO QMC Interim Chair	Patricia Pahl, Health Equity Manager

Compliance Committee Charter

I. CHARTER STATEMENT

The Compliance Committee is created and charged by the Cascade Comprehensive Care (CCC)/Cascade Health Alliance (CHA) Boards to perform risk framing/assessment activities and make recommendations to the CCC/CHA Boards for action and response to reduce regulatory, privacy and compliance risks facing the organization.

II. PURPOSE:

The purpose of the Compliance Committee is to:

1. Develop strategies and tactics to receive, assess and analyze information from varying sources to identify regulatory and compliance risks facing the organization given its operations, information technology, privacy and business plans.
2. To make recommendations to the CCC/CHA Boards on the importance, severity and priority of exposure areas facing the organization. In addition, to recommend possible actions to further determine the extent of possible exposure and/or to remedy and lessen present or anticipated risks.
3. Support the establishment of procedures to assist the CHA Compliance and Privacy Officer in executing and implementing the CHA Compliance Program.
4. Create a forum for Compliance Committee which is comprised of CHA Board members to provide input and direction to the CHA Compliance Officer and obtain key information about identified risks facing the organization and risk mitigation plans.
5. Oversee the implementation and progress of action and monitoring plans designed to reduce risk and support compliance with applicable laws, regulation and company policies.

III. SCOPE:

The Compliance Committee activities include those delegated to it by the CCC/CHA Boards in support of the Compliance Program for organization. In so doing, the Compliance Committee shall ascertain the acceptability of proposed activities when weighed against organizational commitments, goals, regulations, applicable law, and standards of professional conduct and practice.

IV. RESPONSIBILITIES

Responsibilities of Compliance Committee include, but are not limited, to the following:

- Help ensure compliance objectives are being adequately addressed and high impact compliance risks are identified, assessed and reported to the CCC/CHA Boards.

TQS Section 3.A REQUIRED

- Identify, review and assess compliance/risk issues brought forward by CHA Senior Leadership, employees, external stakeholder and plan members and other risk framing information sources.
- Create a compliance risk response plan that includes prioritizing high-risk areas and making recommendations for addressing risk areas.
- On-going assessment of progress with compliance work plans
- Present Annual Report of activities to CCC/CHA Boards.

V. MEETINGS

The Compliance Committee meets no less than quarterly per year. Additional meetings may be called by the Compliance Committee Chairperson to establish greater meeting frequency necessary to conduct the business of the committee and to address critical issues in a timely manner.

The Compliance Committee Chairperson and the Compliance and Privacy Officer or designee will set meeting dates, times, locations and agendas.

VI. MEMBERSHIP

The membership of the committee shall be comprised of

- 3 members of the CHA Board
- CHA CEO
- CHA COO, Compliance and Privacy Officer

Role of a Compliance Committee Member

It is intended that the Compliance Committee leverage the experiences, expertise, and insight of key individuals across a wide spectrum of functions within the organization. Individually committee members should:

- Appreciate the expression and constructive discussion of diverse viewpoints. Understand that each committee member has an equal and full opportunity to express opinions and otherwise contribute to the process.
- Submit risk issues or topics for discussion prior to any meeting for inclusion on the meeting agenda or raise issues during meetings.
- Review and be accountable for their role in the group's efforts and attend Compliance Committee meetings consistently or assign a Chairperson approved delegate (if needed).
- Participate in risk framing exercises and be familiar with how the activities of the committee are relevant to the CHA Compliance and Privacy Programs.

TQS Section 3.A REQUIRED

VII. MEETING STANDARDS

1. QUORUM - a quorum shall exist with at least 50% of the membership in attendance.
2. GUESTS - the Chairperson of the CHA Compliance Committee and the Chief Operations Officer and Compliance and Privacy Officer is permitted to invite as a guest of the committee persons knowledgeable on subjects and issues before the committee, to support educational aspects and provide expertise to the committee when necessary.

3. MINUTES - meeting minutes shall be developed by the Compliance Committee "Recorder" to reflect the actions of the committee. Draft minutes of each meeting shall be submitted to the members of the committee for review and approval prior to the subsequent meeting. The final/approved meeting minutes shall be provided at the next regularly scheduled meeting of the committee.

VIII. SUB COMMITTEES / WORK GROUPS

The Compliance Committee shall in its discretion create and charter formal sub-committees, informal work groups, and engage external consultants and other resources deemed necessary to carry out the activities of the committee. The Compliance Committee shall receive updates from and shall oversee subcommittees and work groups that are created and delegated Compliance Program activities. The Compliance Committee retains its responsibility as delegated to it by the CCC/ CHA Boards. The CCC/CHA Boards remains responsible for the overall activities of the Compliance Program, regardless of the use of subcommittees and work groups.

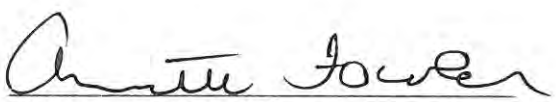
IX. CHARTER REVIEW

This Compliance Committee charter shall be reviewed annually. Material revisions to the Charter shall be approved by the CHA Board.

X. CHARTER APPROVED

Date Chartered: April 10, 2018

Chairperson



Chief Operations Officer

TQS Section 3.A REQUIRED

Cascade Comprehensive Care, Inc.
Compliance Committee Meeting – CCC Boardroom/Ring Central
Tuesday, December 16, 2022 – 7 AM

Present: Grant Kennon, Dr. Graham and Dr. Mirande

CCC: Tayo Akins (CEO), Michael Donarski (COO), Jeff Dover (Compliance Officer), Amanda Hascall (FWA Auditor), and Faith Lee (Compliance Specialist)

Absent:

Meeting called to order 7:04 AM.

Motion to approve Compliance Committee Meeting minutes from September 26, 2022. (**Michael**)
Motion seconded. (Jeff)
Motion passes unanimously.

1. OHA Deliverables– **Discussion only, no motions**
    a. 2022 to Date
    b. 2022 EQR Audit
2. Grievance and Appeals– **Discussion only, no motions**
    a. 2022 Q3 Data
3. Fraud Waste and Abuse– **Approval on the Polices and Procedures Approval- Tracy, Second- Grant**

    Discussion only, no motions on open investigations
    a. Policy and Procedure Review: Approval- Tracy Second- Grant
    b. Current Open Investigations

Adjournment 7:26 AM.

Next meeting: March 28, 2022

Respectfully Submitted,

_____ _____

Grant Kennon, Compliance Committee Chair Jeff Dover, Compliance Officer

Provider Network Management Committee Charter

I. CHARTER STATEMENT

The Provider Network Management Committee (PMNC) is created to perform analysis, assessment, and identify areas of opportunity for provider network adequacy and capacity to serve the Cascade Health Alliance (CHA) membership. The provider network adequacy data reporting is integrated to encompass the following focus areas:

- Member Demographics
- Primary Care Physical (PCP) and Primary Care Dental (PCD) Capacity
- Primary Care Physical and Dental Provider Performance Dashboards
- Specialty Providers by Category and Network Status
- Disease Prevalence
- Grievance and Appeals Data
- Language and Interpretive Services
- Secret Shopper Surveys for
    - PCP/PCD
    - Specialty Providers; and
    - Behavioral Health

II. PURPOSE

The purpose of the Committee is to:

1. Assess network capacity, access, and adequacy, including but not limited to, corrective action plans, policies, guidelines, and analytics to assess CHA provider network adequacy and capacity.
2. Develop and monitor key performance indicators and establish goals/thresholds through reporting and dashboards. Identify and discuss areas requiring action plans to address adequacy and capacity concerns and/or barriers.
3. Make recommendations and actions to the committee on the importance and priority of addressing provider network adequacy, access and capacity concerns.
4. Develop and support the establishment of procedures, processes, and workflows to assist CHA and CCC in executing and implementing provider network strategies.
5. Ensure compliance with rules, regulations, and guidelines under CCO agreements, CFRs, OAR's, and other applicable state and federal requirements.

III. SCOPE

- The PNMC focuses on development of regional PNM monitoring tools to support compliance with rules, laws, and the Oregon Health Authority contract, including without limitation any 3rd party audits, findings and recommendations.
- The PNMC Provides requested information and supports development of the provider network to ensure all covered services are adequately and timely provided.

- Identifies and monitors provider clinics and facilities for gaps in service delivery or potential barriers to care.
- Supports development and implementation of a provider network strategic plan.
- Looks for opportunities and recommends strategies to establish uniformity in contract language revisions and updates as recommended by OHA and/or audit findings.
- Delivers provider clinic education, training, and material as required.

IV. RESPONSIBILITIES

Responsibilities of PNMC include, but are not limited to:

- Monitoring and reporting provider network access, adequacy and capacity.
- Offering recommendations and development for strategies and action plans to ensure appropriate access is maintained for membership of PCPs, PCDs, behavioral health and specialty practitioners.
- Developing of reports to monitor progress and impacts of changes made or needed within the network.
- Identifying and reviewing provider panel issues brought forward by members, stakeholders, CCC employees, Community Advisory Council, and providers.
- Identifying annual provider training topics.

V. MEETINGS

The PNMC will meet monthly, unless canceled due to unforeseen issues. The PNMC will meet no less than once per quarter. Additional meetings may be called by the Chairperson to establish greater meeting frequency necessary to conduct the business of the Committee and to address critical issues in a timely manner.

The PNMC Chairperson or designee will set meeting dates, times, locations, agendas and prepare other meeting materials and documents as necessary.

VI. MEMBERSHIP

The membership of the Committee shall be comprised of (but not limited to):

Chief Financial Officer
Chief Operations Officer
Chief Medical Officer
Provider Network Manager
Director of Member Experience
Director of Clinical Operations
Director of Claims
Director of Quality Management & Health Equity
Compliance Officer
Compliance Analyst
Grievance and Appeals Analyst; and

Credentialing Specialist

Composition shall be reviewed from time to time, as necessary to reflect CHA's and CCC's evolving organizational structure and the oversight needs of the business.

Role of a PNMC Member

It is intended that the PNMC leverage the experience, expertise, and insight of key individuals across a wide spectrum of functions within the organization. Individual Committee members should:

- Appreciate the expression and constructive discussion of diverse viewpoints.
- Understand that each Committee member has an equal and full opportunity to express opinions and otherwise contribute to the process.
- Submit issues or topics for discussion prior to meetings for inclusion in meeting agenda or raise issues during meetings.
- Review and be accountable for their role in the group's efforts and attend meetings consistently or assign a Chairperson approved delegate (if needed).
- Participate in framing issues and be familiar with how the activities of the Committee are relevant to all lines of business.

VII. MEETING STANDARDS

The Chairperson of the PNMC is permitted to invite as a guest of the Committee persons knowledgeable on subjects and issues before the Committee, to support educational aspects and provide expertise to the Committee when necessary.

Meeting agenda and minutes shall be developed by a designee of the Chairperson and be identified as the meeting "Recorder" to reflect the actions of the Committee. Agenda and draft minutes of each meeting shall be submitted to the members of the Committee for review at least two business days prior to the subsequent meeting. The final meeting minutes shall be provided at the next regularly scheduled meeting of the Committee for approval.

VIII. SUB COMMITTIES / WORK GROUPS

The PNMC shall in its discretion create and charter formal sub-Committees, informal work groups, and engage external consultants and other resources deemed necessary to carry out the activities of the Committee. The PNMC shall receive updates from and shall oversee any sub-Committees and work groups that are created and delegated PNMC activities.

IX. CHARTER REVIEW

The PNMC charter shall be reviewed at least annually. Material revisions to the Charter shall be approved by executive management.

CHA PROVIDER NETWORK MANAGEMENT COMMITTEE

August 25, 2022
3:30-4:30 PM
Ring Central Meeting

Attendees	Biagio Sguera - PNMC Chair; Dawna Oksen; David Shute; Leanne Rose; Jeff Dover; Michael Donarski; Kim Walls; Faith Lee; Arthur Petersen; Chanel Smith; Lori Ortiz-Bustos	
1.	Open Meeting; Approve Previous Month's Minutes Michael moved, David 2nd	Biagio
2.	Network Access PCP issues and Nova Health as possible new contracted PCP clinic in the works. Discussed Nova's ability to deliver and next steps. David asks if they would be able to adhere to our PCP modeling. Biagio ran through the PNMC reporting and adequacy slides and discussed adding two new trending slides for both PCP and PCD	Biagio
3.	Quality Metrics performance concerns and updates. No updates, comments, issues, or concerns for August.	Chanel
4.	Medical updates, concerns, and access point issues. No updates, however, David commented on the recent work done to ensure access time to appointments is accurate and adheres to the OAR's and our P&P's.	David

5.	Appeals & Grievances updates. Kim ran through the G&A slides. Dental grievances lead this month. Four untimely NOABD's for last quarter. Discussed that CHA tracks and monitors reasons for decisions being overturned. Less Denials in Q2 2022 when compared to Q2 last year.	Kim
6.	Case Management gaps, concerns, and updates. Arthur expressed some concern about pediatric PCP shortage, discussed Dr. Graham's new pediatric clinic to open in October as a resolution to those concerns. CM and PNM to work together to flesh out disease prevalence data to capture specific diseases with the amount and quality of specific providers on our network to treat those.	Arthur
7.	Compliance and Provider related issues or updates. Credentialing and Contracting issues, concerns, and updates. EQR went well yesterday, reminded team to make sure and think about the data we are chasing and not just a report to have a report but rather that it is purposefully directed towards an end goal.	Jeff
8.	Members Services update.	Lori

Lori asked if there was a way to get her customer service instant up to date access to clinic availability, panel capacity and daily. She will follow with an offline email to flesh out possible solutions. Patricia and team are revamping secret shopper survey procedure and questions to include BH for both adult and pediatrics. These results will directly benefit some of the monitoring and access issues with pediatrics and for identifying any barriers to care.

9. Adjourn

NEXT MEETING
SEPTEMBER 22, 3:30-4:30 PM

UTILIZATION REVIEW COMMITTEE
CHARTER

I. CHARTER STATEMENT

The Utilization Review Committee (URC) is created and charged by Cascade Health Alliance Board of Directors for the purpose of engaging providers and subcontractors in the service area to provide case review, utilization monitoring and clinical expertise to Cascade Health Alliance (CHA) and CHA's providers and subcontractors.

II. PURPOSE:

The purpose of the Utilization Review Committee is to:

1. Analyze utilization patterns, data, and metrics, including identification of patterns. When opportunities to improve clinical or financial outcomes as noted, the URC will be responsible for providing guidance on the development of strategies to address those opportunities.
2. Evaluate coordination and integration services within the provider network, including transitions of care.
3. Provide oversight of the Grievance System, including:
    a. Processing of Coordinated Care Organization (CCO) appeals and reconsiderations.
    b. Oversight of the quarterly grievance reports.
4. Monitors utilization against practice guidelines and treatment planning protocols and policies.
5. Review and approve CCO policies and procedures related to Medical Affairs, Utilization Management, and Case Management as needed.
6. Evaluation of case management and disease management programs provided by the CCO.
7. Provide expertise to CCO regarding clinical workflow and operations.
8. Assuring evidence-based best practices and/or community standards are adopted and utilized by the CCO.
9. Make recommendations to CHA Utilization Review and Medical Affairs for action to improve performance and efficiency of CHA.
10. Serves as a clinical advisory panel as needed.

III. SCOPE:

The URC will focus on engaging providers and clinics concerning clinical initiatives and case review to ensure that CHA members are receiving high-quality cost-effective care. The URC provides clinical expertise and secondary review for appeal and reconsideration cases. The URC serves as an advisory panel to assist CHA in enhancing member experience and achieving the Triple Aim of better care, better health, and reduced cost.

IV. RESPONSIBILITIES

Responsibilities of URC include, but are not limited, to the following:

- Identify and review utilization issues brought forward by providers, stakeholders, or CHA staff.
- Review member cases as assigned to address the appropriateness of denials, limitations, or changes in services or benefits.
- Help ensure clinical initiatives, objectives, and goals are being successfully addressed.
- Report activity to Board of Directors no less than quarterly.

V. MEETINGS

1. Schedule – URC meets on a monthly basis.

2. Special Meetings – additional meetings may be called by the URC Chairperson, CEO, or CMO if necessary, to conduct the business or to address critical issues in a timely manner.

3. Cancellation – the CMO or CEO may cancel a regularly scheduled meeting if deemed appropriate or if the majority of members are not able to attend the meeting. Cancellation notices will be sent to committee membership via email at least one week prior to meeting.
4. Guests – the Chairperson of the URC, CMO or CEO is permitted to invite guests knowledgeable on subjects and issues to any regularly scheduled meeting to provide expertise when necessary.

5. Minutes – meeting minutes shall be developed by CHA staff as designated by the CMO.

6. Decision Making – a majority of members of the URC will constitute a quorum. A decision will be approved by simple majority of members in attendance.

7. Confidentiality – URC members shall be aware of CHA's need for member confidentiality and discretion related to CCO-specific business. The URC will often review member and provide specific data. When possible, CHA will attempt to de-identify member or provider specific information. URC members shall not report member, provider, or CCO specific information or opinions expressed in meetings outside the Committee, other than to follow-up on a member's clinic-specific business.

8. Conflict of Interest – it is recognized that URC members and the organization they represent may be personally, professionally, or financially impacted by the decisions of the Committee. Transparency in sharing conflicts of interest is essential to ensure the integrity of the URC decision making. URC members are required to disclose any potential conflicts of interest pursuant to CHA OI 1-05 *Conflict of Interest*.

VI. MEMBERSHIP

1. Composition – the membership of the Committee shall be comprised of (but not limited to) the following:

   At least five, but no more than fifteen, External Parties:
   - Contracted Providers
   - Partner Organization Administration Staff

   Membership shall reflect a variety of specialties available within Klamath County, including at minimum, primary care, OB/GYN, surgery, pediatrics, and behavioral health. Additions to the committee requires an appointment by the CHA Board of Directors. CHA staff membership must be deemed appropriate by the CMO or CEO. Composition shall be reviewed at least annually, or as necessary to reflect CHA's evolving organizational structure and the oversight needs of utilization management and activities.

2. Term – members serve at least one year, with membership reviewed annually.

3. Chairperson – will be selected and confirmed by CHA Board of Directors with recommendations from Committee membership, CEO, or CMO. The term of chairperson is two years.

4. Vice Chairperson – will be selected and confirmed by CHA Board of Directors with recommendations from Committee membership, CEO, or CMO. The term of vice chairperson is two years.

5. Dismissal – members who are absent, without reasonable cause, from at least 50% of regularly scheduled meetings within a calendar year may be excused from the Committee.

6. Vacancies – members of the URC will be appointed or approved by CHA Board of Directors. When positions are vacated, the URC, CMO, or CEO may either recommend or solicit participation from providers, community partners or clinic administration staff.

7. Member Role – members shall:

   - Review and be accountable for their role in the group's efforts.
   - Participate in exercises and be familiar with how the activities of the URC are relevant to CHA, utilization review, and CHA members.
   - Attend URC meetings consistently or advise of an absence in a timely manner.

VII. ORGANIZATIONAL STRUCTURE

The URC is an advisory committee to the CHA Board of Directors and is sponsored by CHA. This is a standing and ongoing committee. At least one member of the CHA Board of Directors shall also serve on the URC.

VIII. SUB COMMITTEES/WORK GROUPS

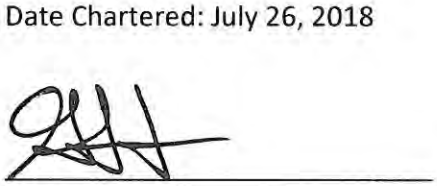
URC may charter subcommittees or project teams as needed upon approval from CMO or CEO.

IX. CHARTER REVIEW

This URC charter will be reviewed annually. Material revisions or updates made by the URC to the Charter will be presented to the Board of Directors for approval.

X. CHARTER APPROVAL

Date Chartered: July 26, 2018



Chairperson

Board Chair

Pharmacy and Therapeutics Committee Charter

I. CHARTER STATEMENT

The Pharmacy & Therapeutics Committee (P&T) is created and charged by Cascade Health Alliance Board of Directors to develop a formulary of pharmaceutical agents, review such formulary on a periodic basis, and make additional recommendations regarding the formulary as the Committee deems necessary and appropriate.

II. PURPOSE:

The purpose of the Pharmacy & Therapeutics Committee is to:

1. Ensure access to clinically sound and cost-effective medications.
2. Oversee the effective and efficient operation of the formulary system and drug policy development.
3. Make formulary recommendations that minimize therapeutic redundancies and maximize cost effectiveness.
4. Develop and manage policies for formulary management activities including prior authorization, step therapies, quantity limitations, and other drug utilization activities that affect access.
5. Support the establishment of procedures to assist CHA in executing and implementing operational performance improvement initiatives.

III. SCOPE:

The P&T Committee will serve in an evaluative, educational, and advisory capacity that will focus on actions that will encourage the use of safe and effective use of pharmaceutical agents that will produce the desired outcomes of drug therapy in a cost-effective manner.

IV. RESPONSIBILITIES

Responsibilities of the P &T Committee include, but are not limited, to the following:

- Periodically conduct therapeutic drug class reviews.
- Consider the relative safety, effectiveness, cost, and other pertinent factors in recommending pharmaceutical agents to be included in the formulary.
- Recommend an implementation period and medical necessity criteria for all pharmaceutical agents placed on the non-formulary status.
- Identify pharmaceutical agents for prior authorization and recommend the prior authorization criteria.
- Identify pharmaceutical agents for quantity limits and recommend the appropriate criteria.

V. MEETINGS

The P & T Committee will meet on a regular basis, but no less than every four months. Additional meetings may be called by the Pharmacy Director to address critical issues in a timely manner.

The Pharmacy Director will set meeting dates, times, locations and agendas.

VI. MEMBERSHIP

The membership of the Committee shall be comprised of (but not limited to):

- Practitioners engaged in active practice from a variety of specialties who participate in the medication-use process.
- Chief Medical Officer
- Director of Pharmacy
- Clinical Pharmacist(s)

VII. TERM

Committee Chair's term will be limited to two years. Composition shall be reviewed from time to time, as necessary to reflect CHA's evolving organizational structure and the oversight needs of our business.

Role of a P & T Committee Member

It is intended that the P &T Committee leverage the experiences, expertise, and insight of key individuals across a wide spectrum of health care specialties. Individual committee members should:

- Appreciate the expression and constructive discussion of diverse viewpoints. Understand that each committee member has an equal and full opportunity to express opinions and otherwise contribute to the process.
- Submit issues or topics for discussion prior to any meeting for inclusion on the meeting agenda or raise issues during meetings.
- Review and be accountable for their role in the group's efforts and attend P &T Committee meetings on a regular basis.
- Actively engage in a forum to work together to improve health care delivery to members served by Cascade Health Alliance.

VIII. MEETING STANDARDS

1. QUORUM - a quorum shall exist with an absolute number of three members in attendance.

2. GUESTS - the Director of Pharmacy is permitted to invite as a guest of the Committee persons knowledgeable on subjects and issues before the Committee, to support educational aspects and provide expertise to the Committee when necessary.

3. MINUTES - meeting minutes shall be developed by a designee of the Pharmacy Director and be identified as the meeting “Recorder” to reflect the actions of the committee. Draft minutes of each meeting shall be submitted to the members of the Committee for review and approval prior to the subsequent meeting. The final/approved meeting minutes shall be provided at the next regularly scheduled meeting of the Committee.

VIII. CHARTER REVIEW

This charter shall be reviewed annually. Material revisions to the Charter shall be approved by Cascade Health Alliance Board of Directors.

Cascade Health Alliance
P&T Virtual Meeting
December 13, 2022

Present: Dr. Cofas, Dr. Chase, Dr. Wirsing, Dr. Akins
CHA: Amin Surani, Kelli Tompkins (Recording Secretary)

Minutes for September 21, 2022 were approved as written

GLP-1 Presentation – Austin Pliska, Pharm-D, BCACP; Ambulatory Care Pharmacist Cascades East Family Medicine Center

Formulary Reviews:
Finasteride 5mg was approved
Trelegy Ellipta was approved with a PA

Formulary Updates:
PA restrictions were removed:

- Pramipexole
- Insulin Lispro Kwikpen

Age restrictions were removed:

- Methylphenidate CD (Metadate CD)
- Methylphenidate LA (Ritalin LA)
- Methylphenidate ER (Concerta)
- Amphetamine-Dextroamphetamine ER (Adderall XR)
- Dexmethylphenidate ER (Focalin XR)

Additional Business Discussion:
Polypharmacy
Deprescribing
Diabetic/Respiratory Supply Transition update
2023 Hepatitis C Treatment Guidelines update

Respectfully Submitted

C Keith Cofas MD

Dr. C. Keith Cofas

Kelli Tompkins

Kelli Tompkins, Recording Secretary

Cascade Health Alliance
P&T Virtual Meeting
April 5, 2022, 7:00-8:00am

Present: Dr. Akins, Dr. Cofas, Dr. Livingston, Dr. Chase, Dr. Wirsing
CHA: Dr. Shute, Amin Surani, Kelli Tompkins (Recording Secretary)

Minutes for December 16, 2021 were approved as written

Formulary Reviews:
Glucometers were approved once per year (CHA discretion to dispense more frequently)
Kerendia non-formulary status was maintained
Trudhesa non-formulary status was maintained
Eprontia non-formulary status was maintained
Topiramate Sprinkles were approved with a PA
Zegalogue non-formulary status was maintained
Zeposia non-formulary status was maintained
Estradiol Weekly Patch PA was removed
Estradiol Bi-Weekly Patch PA was removed
Solifenacin was approved
Trospium was approved
Tolterodine was approved
Tolterodine ER was approved

Formulary Updates:
PA restrictions were removed:

- Liothyronine Tablet
- Bismuth Subsalicylate 262mg Chewable Tablet and Suspension

PA restrictions were removed and QL established:

- Nystatin Cream, Ointment, Powder
- Cetirizine Tablet, Solution
- Loratadine Tablet
- Budesonide 0.25mg/2mL Nebulizer Solution
- Triamcinolone 0.1% and 0.025% Cream and Ointment
- Docusate Sodium 100mg Capsule
- Sennosides Tablet
- Cyproheptadine 4mg Tablet
- Ondansetron Tablet/Ondansetron ODT
- Benzonatate Capsule
- Bisacodyl Suppository
- Lactulose Solution
- Ketoconazole Cream

Policy Reviews:
OAR 410-122-0520 Diabetic Testing Supplies
COVID-19 Home Testing
COVID 2nd Booster Dose

Respectfully Submitted

C Keith Cofas 5/2/22

Dr. C. Keith Cofas

Kelli Tompkins

Kelli Tompkins, Recording Secretary

Cascade Health Alliance
P&T Virtual Meeting
September 21, 2022

Present: Dr. Cofas, Dr. Chase, Dr. Wirsing
CHA: Dr. Shute, Amin Surani, Kelli Tompkins (Recording Secretary)

Minutes for April 5, 2022 were approved as written

Formulary Reviews:
Vuity non-formulary status was maintained
Mounjaro non-formulary status was maintained
Melatonin was approved (No PA)
Testosterone 50mg 1% Gel Packet was added (PA required)

Formulary Updates:
PA restrictions were removed:

- Fluticasone/Salmeterol (Advair DISKUS)
- Wixela Inhaler

Additional Business Discussion:
Fent Check Fentanyl Test Strips
TLO Lice Treatment
Diabetic/Respiratory Supply Transition
Pharmacy Network Contracting

Respectfully Submitted

Dr. C. Keith Cofas

Kelli Tompkins

Kelli Tompkins, Recording Secretary

CASCADE HEALTH ALLIANCE, LLC
CCC BOARD ROOM
UR Committee Meeting – November 15, 2021 – 7AM

Present: Tracy Graham, MD (Chair); Carl Barbee, MD (Vice Chair); Arielle Metz, MD;; Dr Cole Puffer; Amy Boivin, MA,QMHP.
David Shute (CMO); Candice Holohan, Kim Walls, Karen Cole, Kelli Vance, and Shawna Silva
P&R Dental: Gary Dougan, Tracy Sproule, Maureen Obrien, Michael Fiorenza
Absent: Dr. Peter Lusich; Dr. Brandon Chase, Dr. Jared Ogao Dr. Gillian Bayley Theresa Tucker, DDS; Tim Halenkamp, Tayo Akins; and Amin Surani, RPh, and Denise Alves

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Call to Order: 7:01

Review of P&R Dental 2021 Q2 & Q3 Reports:
Presented by Dr Gary Dougan, all reviewed case decisions were confirmed and no questions.

Review of Minutes from October 18, 2021:
Motion to approve with 1 change Amy Boivin remove MD behind her name.

Benevolent Fund Balance:
Dr Shute presented and drew to committees' attention to the total remaining dollars. It was also discussed when new funds are available.

Appeal, Reconsiderations and Benevolent Fund Recommendations:

1. **- Benevolent –** This case was brought back to the committee because of concern on total funds available earlier in the year. Discussed and was moved to approve – Passed Unanimously.
2. **- Benevolent –** Discussed request as it was intended to be bundled with other surgery and motion to approve retro if done with other, or then bring back to committee with more information. – Passed Unanimously
3. **- Benevolent –** Discussed with changes in coverage for 2022 for some hernia but this type is not included. Discussed history of congenital original condition for surgery that led to this condition. Moved to process as a reconsideration as coverable under congenital diagnosis. – Passed Unanimously.
4. **- Reconsideration –** Discussed and moved to uphold denial with discussion with provider on resubmitting with better documentation, Passed Unanimously.
5. **- Reconsideration –** Discussed about member first hip replacement was covered by UR committee due to her mental health condition and unable to quitting smoking. Discussed also co-morbidity rule as coverable service due to the impact that this hip issue has on her Mental condition. Moved to approve reconsideration, Passed Unanimously.

Review of Flex Fund Update:
Dr. Shute reviewed spreadsheet details, and Changes coming to the Flex Fund forms to comply with OHA fund management. Requested Summary for the past few years spending at the end of the year, also requested information and repeat requests and total usage of improved outcomes.

CHA Spending Review:
Dr. Shute reviewed spreadsheet details. Committee discussed and looking forward at data post covid and OHA income evaluations for coverage to be updated with updated income qualified members and cost outcomes.

Meeting adjourned at: 7:52

Next meeting December 20, 2021

Respectfully Submitted,

_____ _____
Tracy Graham, MD Date Shawna Silva, Case Management Assist.

CASCADE HEALTH ALLIANCE, LLC
CCC BOARD ROOM

UR Committee Meeting – February 21, 2021 – 7AM

CHA & Atrio Utilization Review:
Dr Shute reviewed the following: CHA Medical Loss Ratio for overall CHA spend. Variations are present in month to month. CHA is on budget for year. Medical Management CHA Overall spend is month over month through October. Spend is down a little from last year, likely due to membership growth. Figures currently about $299/member/month. Medical Management Overall, relating what goes where: professional fees, inpatient, outpatient, and dental spend. No questions.
Dr Shute reviewed Atrio Auth 1//21 – 12/21 Process of total auths per month are driven by increasing membership. Significant increase. Denied Services detail summary of 47% increase in auth volume with auth denial rate of 6-10%, which is typical. CHA Utilization Management show CHA auth volume over 1000 per month on average. CHA Denied Services is in mid-teens. CHA Auth Turnaround Time (TAT) very close to turnaround time, due to staffing. Down to 8 days in 1/22. Boivin asks about CHA Denial Rate of 15.6%. Stated average is about 10%, as denials vary for Medicaid in Oregon, as Oregon figures shared. We are4 trying to get lower number of days, days are likely due to Medicaid Benefit Package.

Meeting adjourned at: 7:59

Next meeting March 28, 2022
Dr Graham there is conflict with meeting 3/21/22. Relates Dr Ogao and Dr Lusich would have difficulty meeting on 3/21/22 due to Spring Break. URC unanimously requested moving next meeting to Monday, March 28.2022

Respectfully Submitted,

_____ _____
Tracy Graham, MD Date Kim Walls, Appeal & Grievance Analyst

CASCADE HEALTH ALLIANCE, LLC
CCC BOARD ROOM
UR Committee Meeting – March 28, 2021 – 7AM

Present: Tracy Graham, MD (Chair); Carl Barbee, MD (Vice Chair); Amy Boivin, MA,QMHP; Teresa Tucker, DDS; Dr Lusich; Dr Bailey; Dr Ogao; David Shute (CMO); Kim Walls; Karen Cole; Arthur Petersen (Dir Clinical Operations); Tracy Sproule, P&R; Dr Firoenza, P&R; Maureen O'Brien, P&R.
Absent: Arielle Metz, MD; Dr Cole Puffer; Dr Tim Halenkamp; Tayo Akins (CHA CEO); Amin Surani, RPh; Kelli Vance; and Denise Alves.

Call to Order: 7:05

Review of Minutes from February 21, 2021:
Motion to approve by Dr Barbee and seconded by Dr Ogao - approved unanimously.

P&R Dental Q4 2021 IRR: Dr Firoenza presented 264 total reviews for the quarter. He personally reviewed 240 of the cases and agreed with results. No questions.

Special Announcement: Dr Shute shared that Dr Carl Barbee is officially retiring from URC. Barbee shared this is his last meeting and thanked everyone for the experience. Shute thanked him for the years of service, he has been serving since 2010. *Shute shared we would like to fill the position from the perspective of Primary Care.

Benevolent Fund Balance:
Dr Shute presented balance as of 3/23/22 is $126378.42. This includes additional deposit of $50k from CCC Board beginning of 2022. Claims around $17578.15 were paid in February, estimated costs on cases not claimed is $19264.42. Dr Ogao asked if the $50k is standard for yearly discretionary annual deposit. Response was that this has been the case for many years. He wondered if there could be consideration to change the annual deposit since fund hasn't been completely used in last years. Dr Shute will take under consideration; Dr Graham will take this question back to CCC/CHA Board for consideration.

Reconsiderations and Benevolent Fund Recommendations:

1. **- Reconsideration –** Retro referral to Remove Nail Bed for INGROWING NAIL, denied BTL (Line 587). Provider asking for coverage of 3 removals, originally auth approved for 1 nail bed removal. Dr Bailey asked to confirm the original auth wasn't BF (this was confirmed). Bayley motion to approve as issue was bad enough to warrant removal, Ogao seconded. Passed Unanimously.

2 **- Benevolent –**Incisional Hernia w/ Obstruction w/o Gangrene . Ogao commented from general surgery standpoint, member will end up in ER if not already occurring. Ogao moved to approve, Barbee seconded. Passed Unanimously.

3 **- Benevolent –** Umbilical Hernia w/obstruction w/o Gangrene similar story as above, no strangulation. Ogao commented non-reduceable hernia. Ogao moves to approves, Barbee asked if there is documented obstruction, Ogao related might be condition code but doesn't change the need or report. Member is having significant pain regardless. Ogao moved to approve, Barbee seconded. Passed Unanimously.

4 **– Benevolent -** Radial Styloid Tenosynovitis De Quervain (M65.4)—Conservative therapy has failed. Condition is reasonable. Bailey motioned, Barbee seconded, Passed Unanimously.

5 **– Benevolent -** Umbilical Hernia w/o Obstruction or Gangrene – Ogao shared this is affecting his work, not urgent, but standard need to repair. Ogao moved to approve, Barbee seconded. Passed Unanimously. *Amy inquired about cost if patient ends up in ER what is cost of procedure. Shute related is depends on complications that can increase cost & complications, Ogao shared if there is bowel complication there is risk of infection and contamination. If this happens there is higher tendency for occurrence.*

6 Nerve Blocks for 11 patients from Dr Cross, local neurology, for treatment of neuralgia to migraine, but nerve blocks aren't covered in outpatient settings. She has requested BF Consideration of the 11. Each are under $1000 but collectively reach $1909.79. Dr Shute asked URC how they feel about approval of

this type of issue for BF consideration. Dr Shute also shared that Dr Cross wouldn't recommend continued treatment if it was not effective. Questions from URC is for frequency of injection. Dr Shute shared Dr Cross feels these can be effective for pain of neuralgia & migraine. Dr Lusich asked how many of these has Cross requested and frequency. Dr Shute shares this represents Dr Cross 'patients in last 3 -4 months. Dr Lusich asks if BF requests would be similar to hernia surgeries. Dr Barbee commented it seems to be similar to back injections (epidural injections in back or neck), and he thinks they may really be beneficial. Dr Bailey referenced if single never blocks are helpful, it seems reasonable we just need to keep eye on numbers. All agreed to process as BF, at least for these 11. Dr Shute shared he appreciates URC input.

Review of Flex Fund Update:
Dr. Shute shared the update is for non-covered medical services. Dr Bailey asked what generator batteries are for. Dr Shute & Arthur Peterson related at this time, requests for Flex Funds are reviewed by case manager for medical necessity. In regard to the batteries, that item is necessary to run medical devices. Arthur offered to report back on the particular items. Dr Bailey replied there is no need to report back and that she was just wondering. Amy asked what annual amount for Flex Funds is, Arthur and Dr Shute related the amount could change with environmental (like air quality) or other issues. Dr Shute referenced these are items to improve health outcomes beside what is traditionally approved. Dr Graham asked about Lice Treatment, as it's covered by OHP. Shute offered to get back to URC on that, but Committee related no need to bring back.

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Meeting adjourned at: 7:54

Next meeting April 18, 2022

Respectfully Submitted,

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Tracy Graham, MD Date Kim Walls, Appeal & Grievance Analyst

CASCADE HEALTH ALLIANCE, LLC
CCC BOARD ROOM
UR Committee Meeting – April 18, 2022 – 7AM

Present: Amy Boivin, MA, QMHP; Dr. Peter Lusich; Dr Jarred Ogao; David Shute (CMO); Kim Walls; Karen Cole; Arthur Petersen (Dir. Clinical Operations) Arielle Metz, MD; Dr Tim Halenkamp.

Absent: Tracy Graham, MD (Chair); TBD (Vice Chair); Dr. Gillian Bailey; Dr Cole Puffer; Teresa Tucker, DDS; Tayo Akins (CHA CEO); Amin Surani, RPh; Kelli Vance; and Denise Alves.

Call to Order: 7:08

Review of Minutes from March 28, 2021:
Motion to approve by Amy Bovin and seconded by Peter Lusich - approved unanimously.

Benevolent Fund Balance:
Dr Shute presented balance as of 3/23/22 is $126,378.42. With tracking $76,000 as of this point this includes additional deposit of $50k from CCC Board beginning of 2021 and again in 2022. Amy Bovin asked if how it is allocated that are not completed and paid for and will follow up with those details next month.

Reconsiderations and Benevolent Fund Recommendations:

1. **Reconsideration –** Dr Halenkamp presented this as he did the original denial due to lack of notes for endometriosis. Now, with this reconsideration provided the medical history provided for endometriosis and this was reviewed by Dr Shute on review. Bringing
Dr Metz stated 85% of time hysterectomy is cure and leads to no future treatments that are expensive and not definitive. Dr Metz to address missing notes and more comprehensive history to be included. Dr Halenkamp stated that often has requested to search epic for member history or labs to fill in gaps of missing documentation. Dr Shute requested if time for more documentation and request was March 9th, and denial 3/26 and Dr Metz to have notes faxed in today. Dr Shute requested to defer and approved by Amy and second by Ogao. Passed Unanimously.

2. **Reconsideration –** Dr. Shute presented case, Dr Metz stated she is familiar with member and has failed nerve block failed and would not recommend a 3rd and stated that member needs coverage for internal meds anal nerve pain requested with OHSU anal rectoral surgeon. Dr Metz stated temporary relief but …. Dr Metz ask cost and Dr Shute stated $48 pretreatment Move to approve and this wanting more definitive management for her Ogao second. Passed Unanimously.

3. **- Reconsideration –** Dr. Shute presented case and stated if Metz moved to approve and Ogao seconded. Passed Unanimously.

4. **Benevolent –** Skipped due to approved in reconsideration.

5. **- Benevolent –** Dr. Shute presented case Ogao moved to approve and Second By Lusich approved Unanimously.

6. **- Benevolent –** Dr. Shute presented and advised no covered-on guidelines and questioned by Dr Metz about this being covered as a covered as part of previous surgery. Dr. Metz stated this is a lawsuit issue and asked if coding on care for current condition verses new event. 10/5/2020 Lap Coly done. Dr Metz requested to reinvestigate as complication to previous surgery. Dr. Shute can check on guidelines and . Dr Ogao requested to move to cover under complication if not able to then cover on BF fund. Second by Amy Bovin. Passed Unanimously.

7. **- Benevolent –** Dr. Shute presented, and Dr Metz moved to approve Second by passed with 1 opposed.

CASCADE HEALTH ALLIANCE, LLC
CCC BOARD ROOM

UR Committee Meeting – April 18, 2022 – 7AM

Review of CHA Utilization Review Update: Dr. Shute presented 2019-2022 increased to 27,000+ member with member spend maintaining flat rate per member per month and attributed to member who are less ill.
Dr Metz asked about forecasted member increase for 2022 and question increase, Dr. Shute stated that redetermination was passed due to Covid, and no one was moved CMS to redetermination to happen when covid ends and looking and happening last summer fall 2022 and anticipate membership to decrease then. Dr Shute offered follow if any questions and can present again in further meeting.

Review of Flex Fund Update: Dr. Shute presented about Flex Fund and most costs are for YMCA fitness cost. Ogao stated that he goes into YMCA and usage and follow up as he has seen stacks of cards not being used and is concerned about wasted costs for cards that go unused. Dr Bovin asked if adding a time limit on cards to limit. Shawna added that the punch cards were the alternative to monthly memberships. CHA can investigate smaller amount Past information on inquiries to be brought back on Lice Kits reasons and YMCA option follow up.

Meeting adjourned at: 7:50

Next meeting May 16, 2022

Respectfully Submitted,

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Tracy Graham, MD Date Shawna Silva, Case Management Assist II

CASCADE HEALTH ALLIANCE, LLC
CCC BOARD ROOM
UR Committee Meeting – April 18, 2022 – 7AM

Present: Amy Boivin, MA, QMHP; Dr. Peter Lusich; Dr Jarred Ogao; David Shute (CMO); Kim Walls; Karen Cole; Arthur Petersen (Dir. Clinical Operations) Arielle Metz, MD; Dr Tim Halenkamp.

Absent: Tracy Graham, MD (Chair); TBD (Vice Chair); Dr. Gillian Bailey; Dr Cole Puffer; Teresa Tucker, DDS; Tayo Akins (CHA CEO); Amin Surani, RPh; Kelli Vance; and Denise Alves.

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3. **Reconsideration –** Dr. Shute presented case and stated if Metz moved to approve and Ogao seconded. Passed Unanimously.

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5. **Benevolent –** Dr. Shute presented case Ogao moved to approve and Second By Lusich approved Unanimously.

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7. **Benevolent –** Dr. Shute presented, and Dr Metz moved to approve Second by passed with 1 opposed.

CASCADE HEALTH ALLIANCE, LLC
CCC BOARD ROOM
UR Committee Meeting – April 18, 2022 – 7AM

Review of CHA Utilization Review Update: Dr. Shute presented 2019-2022 increased to 27,000+ member with member spend maintaining flat rate per member per month and attributed to member who are less ill.
Dr Metz asked about forecasted member increase for 2022 and question increase, Dr. Shute stated that redetermination was passed due to Covid, and no one was moved CMS to redetermination to happen when covid ends and looking and happening last summer fall 2022 and anticipate membership to decrease then. Dr Shute offered follow if any questions and can present again in further meeting.

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Meeting adjourned at: 7:50

Next meeting May 16, 2022

Respectfully Submitted,

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Tracy Graham, MD Date Shawna Silva, Case Management Assist II

CASCADE HEALTH ALLIANCE, LLC
CCC BOARD ROOM
UR Committee Meeting – June 20, 2022 – 7AM

Present: Tracy Graham, MD (Chair); Amy Boivin, MA, QMHP; Dr. Peter Lusich; Dr Jarred Ogao; Dr. Gillian Bailey; David Shute (CMO); Kim Walls; Karen Cole; Arthur Petersen (Dir. Clinical Operations) Arielle Metz, MD; Teresa Tucker, DDS; Shawna Silva.

Absent: TBD (Vice Chair); Dr Cole Puffer; Tayo Akins (CHA CEO); Amin Surani, RPh; Dr Tim Halenkamp

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Call to Order: 7:04

Review of Minutes from April 18, 2021:
Motion to approve by Amy Bovin and seconded by Peter Lusich - approved unanimously.

Follow Up Coverage of Complications:
Dr. Shute presented the Guideline Note, and Prioritized List of health services Prioritized List. Details and discussion on this topic and committee wanted to peruse more information including historical record of time frames and ask to have HERC committee when reviewed and details and ask to have this GN rereviewed. Wanted member of the board and minutes when this was created. Dr. Arthur Peterson as pointed out the process to submit additional information to update and challenge the GN. Dr. Graham provided addition statement to reply with "That practicing surgeons disagreed" Dr Shute stated we will bring back: Minutes and Literature reviewed for this decision made and then after review can submitted evidence to challenge.

Committee Charter Review -Amendments, Deletions Updates:
Charter was reviewed and discussed that no other changes were made last year and confirmed no changes listed. Motion by Ogao moved to approve as is and seconded by Peter Lusich - approved unanimously.

Vice Chair Recommendations:
Presented to the board and Dr. Peter Lusich volunteered. Dr Shute stated that it will be presented to the board and brought back to UR in July.

Review: CLINICAL PRACTICE GUIDELINES POLICY AND PROCEDURE:
Dr. Shute presented motion by Amy Bovin and Ogao second to approved and passed unanimously.

Benevolent Fund Balance:
Dr Shute presented balance as of 06/06/2022 is $120,387.38 With tracking $42.438.12 as of this point this leaving a balance of 77,949.26. Dr. Graham asked to confirm, and Karen Cole presented the math and details.

Benevolent Fund Recommendations:

1. **Benevolent-** Board discussed the details confirmed that to remove is the best Dr. Olga moved to approve the Dr. Metz seconded. Motion passed unanimously.

2. **Benevolent -** Board discussed the case and Dr Tucker moved to approve Olga second and motion passed unanimously.

3. **Benevolent -** Board discussed the details and Dr Olga discussed on merit and moved to approve, Bovin seconded Motion passed unanimously.

4. **Benevolent –** Board discussed case and details and why Dr bailey to follow up with Koehler and defer to next month decision with more clarification or resubliming on details. Dr Metz moved to defer and Bovin seconded, the motion passed unanimously to defer.

5. **Benevolent –** Board discussed about how congenital deformities are not covered by OHA and discussed case detail. Olga moved to approve, and Amy Bovin moved to

seconded, motion approved unanimously.

6. **Benevolent –** This was a reconsideration moved to Benevolent fund so no letter from provider. Ogoa pointed out missing results of Ultrasound and more details with letter from provider on details. Found details on page 109 of evaluation and Dr. Olga motion to approved second by Dr. Lusich and motion approved unanimously.

7. **Benevolent –** Olgoa moved to approve but Dr. Metz question history of PT and how long PT is needed to evaluate and Bailey confirmed that her opinion is that PT is going to cost more and not effective. Bovin Second and motion passed unanimously.

8. **Benevolent** - Board discussed finger cyst and details of case Dr Bailey present more evidence and Dr Metz moved to approved Dr Ogoa second, Motion approved unanimously.

9. **Benevolent -** Dr Bailey presented as her patient and stated that long time working with workmen's comp and CT confirmed issues and she was confused on the high cost estimate listed as it was only the removal of the bone. Dr. Shute stated that the estimate was based on codes and provided by claims and is only an estimate. She confirmed the workmen's comp closed case and determined that it was prior condition but Dr. Bailey confirmed that she had appealed with Workmen's Comp that it as not. Motion to approved by Olga second by Bovin and motion approved unanimously.

Review of CHA Utilization Review Update: Dr. Shute the information on the slide and references of 20,934 to 25,385. Noted that the 2022 spend is down from 2021. Shared the 50% of member to date are not using benefits Dr. Metz question outreach for maintenance of well care, and Dr. Shute confirmed that it is a tracked matrix of member PCP's. Then Dr. Bovine asked to move higher item in agenda to allow more time for this information to be considered as often skipped with time is limited. Dr, Ogoa then pointed out the 9 cases is too many to review in 1 hour and then have other agenda items and requested not to skip meetings. Dr. Shute stated that we will take this into consideration.

Review of Flex Fund Update: Were presented in packets and no questions presented for review.

Meeting adjourned at: 8:04

Next meeting July 18, 2022

Respectfully Submitted,

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Tracy Graham, MD Date Shawna Silva, Case Management Assist II

CASCADE HEALTH ALLIANCE, LLC
CCC BOARD ROOM
UR Committee Meeting – August 15, 2022 – 7AM

Present: Tracy Graham, MD (Chair); Dr. Peter Lusich; Amy Boivin, MA, QMHP; Dr Jarred Ogao; Arielle Metz, MD; David Shute (CMO); Arthur Petersen (Dir. Clinical Operations); Kim Walls; Shawna Silva.

Absent: Dr. Gillian Bailey; TBD (Vice Chair); Dr Cole Puffer; Teresa Tucker, DDS; Tayo Akins (CHA CEO); Amin Surani, RPh; Dr Tim Halenkamp

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Call to Order: 7:03

P&R Dental – 2022 Q1 & Q2 Reports:
Gary Dougan Presented the information from Q1 and Q2 reports and asked if any questions and non asked. P&R dropped off call.

Review of Minutes from June 18, 2022:
Notes reviewed and Amy Boivin moved approve and Dr Ogao second - approved unanimously.

Vice Chair Recommendations Follow Up:
Dr. Shute presented that Dr. Peter Lusich was presented to the board as volunteering for Vice Chair and approved.

Appeals & Grievance Q1 2022:
Kim Walls Presented Q1-2022 report and average membership is over 21,020 and jumping over 24,000 with no complaint excess 30 days. 1602 NOABDs with denials of requested service. Highest in pharmacy of 646, with Specialty Care next at 333, Imaging at 101, and Dental at 87. ABA denied for selective mutism not ADHD. Overturned rate at 37.5% but only deeper if over 50%. Expedited is mainly requested verse 16 day standard service for 72 hours turnaround and nothing was qualifying for expedited. One hearing request in Q1 (side note that have had 2 hearings in Q2.)

Flex Funds Update:
Dr. Arthur Peterson presented and stated will work on getting synopsis information for next review. Dr Metz, requested to look at local purchase options verses buying from Amazon. Dr. Shute stated that this was done through amazon as a streamlining of process and convenience for members. Bovin asked about YMCA cards and Dr. Peterson stated he reached out to YMCA and confirmed that card are punch cards and if unused will not issue 2nd card. We are asking for summary data on 2nd card issue and timeframes. The group discussed the benefits of the YMCA cards.

Benevolent Fund Balance:
Dr Shute presented balance as of end of June $120,143.60 with many claims that have been approved but not yet billed. If all fund used will leave $62,776.56 this is a comfortable place to allow approvals with the board encouraging the use of funds for the benefit of members.

Benevolent Fund Recommendations:

1. **Benevolent –** Recap of case discussed in June. Dr Ogao moved to approve and Dr Metz seconded - Passed Unanimously

2. **Benevolent –** Case discussed and was referred to BF by Dr. Shute, Dr. Ogao stated that this member was see by him and is not sure why member did not follow up with treatment but felt there were more questions on this case as it was previously approved by CHA. Dr Graham agree with concern the request with no physical exam included. Dr Ogao moved to denied, and Dr. Metz brought out that member is still smoker, Dr. Metz seconded - Denied unanimously.

3. CA501L3S - Soresen **– Benevolent –** Case was presented with letter from member, Dr Ogao moved

to approve, Dr. Metz asked why this was not emergency, Dr. Shute stated that in updated guidelines for 2022 and ventral hernia are not covered. Dr. Metz seconded - passed unanimously.

4. **Benevolent –** Case was presented and reviewed Dr. Smith's letter and Dr Ogao moved to approve, Dr. Metz seconded - passed unanimously.

5. **Benevolent –** Case was presented and reviewed Dr. Hosack's letter and discussed, Dr Ogao moved to approve and Dr Metz seconded - Passed Unanimously.

6. **Benevolent –** Case was presented for non-funded conditions, and review of letter from member. Discussed and clarification that was started as an appeal requested that was upheld and referred to Benevolent Funds. Condition and details discussed and noted that Medicare did cover but that this is a non-funded line item for Medicaid. Dr Metz moved to approve and Dr Ogao seconded – Passed Unanimously.

7. **Reconsideration –** Case was presented and discussed that the diagnosis was a non-funded/ not covered for the procedure and does not pair with coverage treatment, plus the surgery is not covered as a surgery. and evidence for this treatment of long term benefit. Dr. Shute confirmed that this is a common procedure. Discussed that diagnosis of Bells Palsy is considered limited deration with no long-term issues. Dr Metz asked if this is coverable under OHP and Dr Shute reminded that this is coverable if reconsidered and not a Benevolent Funds request. Items discussed for appropriate treatment for least costly preventive treatment. Dr. Metz moved to approve and Amy Bovin seconded – Passed Unanimously

Meeting adjourned at: 7:41

Next meeting September 19, 2022

Respectfully Submitted,

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Tracy Graham, MD Date Shawna Silva, Case Management Assist II

CASCADE HEALTH ALLIANCE, LLC
CCC BOARD ROOM
UR Committee Meeting – --September 19, 2022 – 7AM

Present: Tracy Graham, MD (Chair); QMHP; Dr. Peter Lusich; Amy Boivin, MA; Dr Jarred Ogao; Arielle Metz, MD; David Shute (CMO); Arthur Petersen (Dir. Clinical Operations); Kim Walls; Shawna Silva.

Absent: Dr. Gillian Bailey; TBD (Vice Chair); Dr Cole Puffer; Teresa Tucker, DDS; Tayo Akins (CHA CEO); Amin Surani, RPh; Dr Tim Halenkamp

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Call to Order: 7:03

Review of Minutes from August 15, 2022:
Notes reviewed and Amy Boivin moved approve and Dr Ogao second - approved unanimously.

Flex Funds Update:
Dr. Petersen presented new chart showing monthly flex fund expenditures and YTD total $16,643.
Explanation that these are funds used for individual members for health-related non-covered items.

Benevolent Fund Balance:
Dr Shute presented balance as of end of June $120,143.60 with many claims that have been approved but not yet billed. If all fund used will leave $47,636.57.

Case Review:

1. **Benevolent** – Case discussed, and Dr Metz moved to approve, and Dr Ogao seconded - Passed Unanimously

2. **Benevolent** – Case discussed, and Dr Boivin moved to approve, and Dr Ogao seconded - Passed Unanimously

3. Benevolent – Case discussed, and committee made note of infrapatellar fat pad that was not addressed by the planned procedure; Other committee members noted that it was improving without surgery; Merits of the case were further discussed and ultimately Dr Metz moved to approve and Dr Ogao seconded - Passed Unanimously

4. Benevolent – Lengthy discussion of the merits of this case ensued; Committee noted presence of inguinal hernia and left adnexal mass also; After some discussion and Dr Metz moved to deny and bring case back next month after discussing further with plan of care with provider; Dr Ogao seconded - Passed Unanimously (I understood that CHA would bring back next month for further review)

5. Benevolent – Case discussed, and Dr Ogao moved to approve, and Dr Boivin seconded - Passed Unanimously

6. Benevolent – Case discussed and Dr xxxxx moved to approve and Dr yyyyy seconded - Passed Unanimously (This case was withdrawn as a BF, by Dr Shute)

7. Benevolent – Case discussed, and Dr Ogao moved to approve, and Dr Metz seconded - Passed Unanimously

8. Reconsideration – Case discussed, and Dr Ogao moved to approve, and Dr Bovin seconded - Passed Unanimously

CASCADE HEALTH ALLIANCE, LLC
CCC BOARD ROOM
UR Committee Meeting – --September 19, 2022 – 7AM

Authorizations from Specialists to other Specialists:
Dr. Shute requested guidance from the committee about out of area specialists referring to other out of area (OOA) specialists. Applicable OARs were reviewed and several example scenarios were discussed. Historically these are being accepted and approved. Committee asked what has brought this question to head. Sanford clinic has expressed concern of PCPs bearing the administrative burden of all auth requests. **Action**: Dr. Boivin moved to **table discussion for review after obtaining additional input from other primary care providers** and Dr. Metz seconded – **Passed** Unanimously

Example 1: OOA orthopedist refer member and submit auth request for follow-up physical therapy. (Committee comments supported this as appropriate);

Example #2 OOA peds specialty/subspecialty referring and submitting auth request for other OOA peds specialty. (Concerns by Dr. Graham were voiced citing hypothetical example of child being referred to peds cardiology for a murmur from a peds GI specialist who may or may not be clinically practiced in assessing innocent murmurs from those needing additional workup. Potential for PCP liability mentioned.

Example: #3 OOA specialist referring to pain management (Concerns of this scenario by staff and committee were voiced.)

Meeting adjourned at: 7:41

Next meeting October 17, 2022

Respectfully Submitted,

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Tracy Graham, MD Date Arthur Petersen, Director Clinical Operations

CASCADE HEALTH ALLIANCE, LLC
CCC BOARD ROOM
UR Committee Meeting – October 17, 2022 – 7AM

Present: Tracy Graham, MD (Chair); QMHP; Dr. Peter Lusich (vice Chair); Amy Boivin, MA; Dr Jarred Ogao; Teresa Tucker, DDS ; Dr. Gillian Bailey; David Shute (CMO); Arthur Petersen (Dir. Clinical Operations); Kim Walls, Karen Cole, and Shawna Silva.

Absent: Arielle Metz, MD; Dr Cole Puffer;; Tayo Akins (CHA CEO); Amin Surani, RPh; Dr Tim Halenkamp

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Call to Order: 7:02

Review of Minutes from September 19, 2022:
Notes reviewed and Dr Ogao moved approve and second Amy Boivin - approved unanimously.

Flex Funds Update:
Dr. Shute presented new chart showing monthly flex fund expenditures and YTD total $19,597. Explanation that these are funds used for individual members for health-related non-covered items. Also discussed if the program was running as wanted, and Dr. Shute stated that this is an evolving and yes, the program is running but will be revamp and broadened under flex funds.

Benevolent Fund Balance:
Dr Shute presented balance as of end of June $120,143.60 with many claims that have been approved but not yet billed. If all fund used will leave $55,282.32.

Case Review:

1. – **Benevolent** – Case Removed and deferred to next meeting, pending additional information from Dr Smith about plans of care.

2. – **Reconsideration** – Case discussed with request for missing ultrasound as referenced in the guide note criteria, however it was discussed in notes of internal exam of member by provider. URC agreed unanimously that the internal exam notes served the same purpose that an ultrasound would. Dr. Ogao moved to approve, and Dr Bailey seconded - Passed Unanimously

3. **Reconsideration** – Case discussed, and URC stated that the guide note application and verbiage by reviewer was against the notes of the provider and were written per the guide note criteria and denial against the verbiage on the medical notes that were worked with in guide notes description. URC determined that the provider notes did meet guide note criteria. Dr Graham expressed concern that there could be further implication if surgery was not performed and complication arose. Dr. Bailey moved to approve, and Dr Ogao seconded - Passed Unanimously

5. **Reconsideration** – Case discussed about why Oregon Surgical had this case Dr. Shute stated that when an obese member has gastric services and there is higher risk and referred out-of-area that local surgeons agree is best practice, and Dr. Ogao agreed. Dr Lusich moved to approve, and Dr Ogao seconded - Passed Unanimously

CHA Utilization Review:
Dr. Shute presented slide including Medical Loss Ratio, Member Spend and Member Utilization of Primary Care Services:

Discussion on Medical Loss Ratio: Opened for discussion, and no question or clarification requested.

Member Spend: Opened for discussion, and no question or clarification requested.

Amy Bovin, MA asked about if there was any further analysis if those were found to be higher users of emergency services. Dr. Shute confirmed that there was an analysis of ED usage with dental related care and found that it was consistent with member who had not had dental care.

Member Utilization of Primary Care Services: Opened for discussion, and no question or clarification requested.

Dr. Lusich asked about the review of coverage and if that is going to be updated for evaluation. Dr. Shute confirmed that the looking that it was pushed back and is looking to update the redetermination of eligibility of coverage to restart Q1 of 2023. 1115 Waiver is updated to start January, 202, and the OHA is looking at programs to allow member to stay on coverage and stated that all kids 0-6 will have uninterrupted coverage for at least 2 years to ensure no lack of care. Also looking at adult option to keep ensured coverage, if possible, under the Bridge Plan.

Dr. Ogao brought up a discussion about the 22% not see by PCP and requested what is being done to fix that. Dr. Shute presented that CHA process when member is added we do outreach called to set up PCP and encourage initiation establishing care and work with CHA text program to remind members. Dr Shute, referred to Dr. Graham about as the clinic PCP side of getting patients established and she stated that

Dr Graham stated that it would be good to look at those who are not accessing care what are they doing for care and if there is a delay in care that might lead to more serious health conditions down the road. Dr. Shute stated that we will investigate that and if member is accessing other care might be in BH and ED services.

Dr Shute asked for a motion to direct CHA to review the 22% of members that have not established PCP care: Dr. Bailey moved to approve, and Dr Ogao seconded - Passed Unanimously.
Dr Bovin asked when that data will be available if next month, and Dr Shute stated to bring back in about 3 month when enough data is collected to present to URC.

Q2 2022 Grievance Systems Analysis
Kim Walls present 22/Q2 with enrollment of 24,702 and will look at high capture rate moving forward. All Grievances were resolved in 30 days. Highest was interaction with provider plan, second was access to care, and the third was quality of care. These three are the usual top three.

NOABDs for Q2 of 1331 but low give high number of members. Narrative of NOABDs with most in Pharmacy and then Specialty of care. Five untimely NOABDs (Notice of Adverse Benefit Denial), with 2 medical that were day 15 and 2- NEMT (Translink) services denials at day 23 and one by day 35. The required timeframe if within 14 days.

Appeals had 25 in Q2 with 24 denials for requested services and 1 for a reduction of service. With highest number of appeals in Specialty Care at 11. Almost half of appeal were requested expedited processing and none of them qualified for expedited processing service. There were 3 hearing, 2 were overturn prior to hearing and the 3rd was withdraw before hearing. No provider hearing.

Open to any further decisions. Dr. Shute asked if all knew what NOABDs, and Kim confirmed it stands for NOABDs (Notice of Adverse Benefit Denial).

Dr. Shute stated that OHA is making changes to the NOABD letters, and we are updating and adding more information with changes coming in the next month or 2 and to make committee aware of changes.

Dr Shute Opened for discussion, and no question or clarification requested.

Meeting adjourned at: 07:54

Next meeting November 21, 2022

Respectfully Submitted,

_____		_____
Tracy Graham, MD	Date	Arthur Petersen, Director Clinical Operations

CASCADE HEALTH ALLIANCE, LLC
CCC BOARD ROOM
UR Committee Meeting – November 21, 2022 – 7AM

Present: Tracy Graham, MD (Chair); Amy Boivin, QMHP; Dr Jarred Ogao; Gillian Bayley, MD; David Shute (CMO); Arthur Petersen (Dir. Clinical Operations); Kim Walls, Karen Cole, and Shawna Silva; P&R Dental- Tracy Sproule, Maureen Obrien; Michael Fiorenza

Absent: Teresa Tucker, DDS; Dr. Peter Lusich (vice Chair); Arielle Metz, MD; Dr Cole Puffer; Tayo Akins (CHA CEO); Amin Surani, RPh; Dr Tim Halenkamp

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Call to Order: 7:06

P&R Dental : Inter-rater Reliability - 2022 Q3 Report:
Presented by: Michael Fiorenza with P&R, reviewed report, Dr Shute asked when the last OHA hearing occurred, and Maureen confirmed that in Q4, 2021 one was scheduled but was cancelled. Kim later confirmed was withdrawn.

Review of Minutes from October 17, 2022:
Notes reviewed and Amy Bovin moved approve and second by Dr. Ogao - Approved Unanimously.

Flex Funds Update:
Dr. Arthur Peterson presented, $20,000 spend with $50,000 total allocation. Working on revamping and rebudgeting program for 2023. Dr. Graham asked if Flex Funds roll over and Dr. Shute confirmed they do not roll over, but stated that there is an expansion of coverage by OHA under HRS funds. For example CCOs are now providing Air Filters and Air conditioners. Flex fund administration will be moving in 2023 from Case Management to Health Equity.

Benevolent Fund Balance:
Dr Shute presented balance as of end of June $120,143.65 with many claims that have been approved but not yet billed. If all fund used will leave $36,409.56, these funds will roll over to 2023, and will be combined with the typical allotted funds of $50.000 approved by the board in January 2023. Confirmed that there was more than the budgeted $50,000 in 2022 due to roll over due to unspent prior funds along with the 2022 allotted funds of $50.000 approved by the board. He stated that the board will want to look more decerning at cases. Amy Bovin stated that the board will need to look at reprioritizing spending since so much spent this year. Dr Ogao asked if the fund is being increased in 2023 and Dr Graham confirmed that is no increase. Dr Bailey asked if there were going to be any restrictions like stop smoking in acted by CHA. Dr Graham confirmed that Smoking cessation is a state mandate. Dr Bailey talked about repeated cases types often like trigger finger, hernias, and ganglion cysts talked about if CHA covered the cortisone injection it would be a better option, to cover more people, and result in less asks for surgery.

Case Review:

1. **Benevolent** – Case represented and discussed including additional information re adnexal lesion. Dr. Shute talked with Dr. Smith and notes are on page 16. Asked Dr. Smith if he wanted the case withdrawn because of patient's refusal of Pre-op Covid testing, Dr. Smith requested review by committee. Dr. Shute asked to confirm if testing is needed for outpatient surgery at Sky Lakes, Dr Ogao confirmed no covid testing required. Dr Ogao stated that member unwillingness to get tested for other surgery that does not seem right. Motion by Dr Ogao, seconded by Dr. Bayley to uphold denial. Denied- Passed unanimously.

2. **Benevolent** – Dr Bayley and Dr. Bovin discussed case, Dr Graham agreed that hand dominance to be considered. Patient with long term issues and consideration of working age. Dr. Bayley Motion to approve, seconded by Dr. Ogao. Passed unanimously.

3. – **Benevolent** – Bayley stated that this is similar to prior case, but member has had issue for shorter timeframe. Dr. Bayley Motion to deny, seconded by Amy Bovin. - Motion Passed Unanimously

4. – **Benevolent** – Dr. Graham asked why this was not fixed as a baby and Dr. Bayley discussed that members were told nothing could be done. Dr Graham stated that it was criminal as Shriner's could have taken care of this in infancy. Other discussion acknowledged that sometimes these types of things are missed. Amy Bovin motion to approve, seconded by Dr. Ogao. - Motion Passed Unanimously

5. – **Benevolent** – Dr. Ogao discussed member case and questioned member's BMI. Member vital signs are missing from notes. He stated that a reduced BMI shows better outcome post-surgery. Dr. Ogao moved to deny due to incomplete documentation and Amy Bovin seconded. Dr. Shute confirmed for clarification this is to deny but Dr. Smith can resubmit with more documentation, Dr Graham confirmed yes. Motion to Deny Passed Unanimously.

6. **Benevolent** – Trigger finger discussed, and Dr Hossack stated concerns about possible carpel tunnel as well. The committee discussed possibly combining the two surgeries, but this is not Dr. Hossack's recommendation. Dr. Bayley motioned to approve, seconded by Dr. Ogao. - Motion Passed Unanimously.

7. **Benevolent** – Dr. Bayley discussed that patient has self-paid for injections. Amy Bovin moved to approve, and Dr. Bayley seconded – Motion Passed Unanimously.

8. **Benevolent -** Request for ganglion cyst excision. Member also has carpel tunnel which is a covered condition. Dr. Bayley questioned if this surgery can be covered by CHA if the cyst is causing the Carpel Tunnel and noted in documentation. Dr Shute asked if we can change this Benevolent Fund request to a reconsideration. Dr Bayley moved to process as a Reconsideration, approved by exception, and Dr, Ogao seconded. - Motion Passed Unanimously.

9. **Benevolent** – This came in as a member appeal for Ventral Hernia Repair but the denial was upheld. Dr. Shute referred this case to the committee for consideration under Benevolent Funds. This is due to the severity of symptoms outline by the member in her appeal request. Dr Bayley requested to have Dr Shute elaborate. Dr. Shute asked if member appeal letter available which was not included in the case for the packet. It was unable to be retrieved and shared at the time of the meeting. Dr Ogao stated that this is very straightforward and moved to approved. Dr. Bayley seconded. -Motion Passed Unanimously.

10. **Reconsideration** – Dr Shute presented and stated that the documentation does not meet guideline notes because hormone therapy has not been tried and failed but acknowledged the documentation states that the member has history of blood clots and unable to do hormonal therapy. Dr. Ogao moved to approve, and Dr Bayley seconded, Dr Graham asked if ok to approve when does not meet under the guideline notes, Dr Shute stated that it can be approved by exception due to members history. This can be done by the committee on discretionary bases but not often. Motion Passed Unanimously.

CHA Utilization Review:
Dr. Shute presented utilization data year to date showing an 8.5% increase in membership and a 3.8% in cost PMPM. CHA will continue to monitor spend going forward.

CASCADE HEALTH ALLIANCE, LLC
CCC BOARD ROOM
UR Committee Meeting – November 21, 2022 – 7AM

Q3 2022 Grievance Systems Analysis-
Kim presented for information purposes only and committee stated no questions.

Meeting adjourned at: 8:00

Next meeting December 19, 2022

Respectfully Submitted,

_____		_____
Tracy Graham, MD	Date	Arthur Petersen, Director Clinical Operations

ACTIVE MEMBER DEMOGRAPHICS

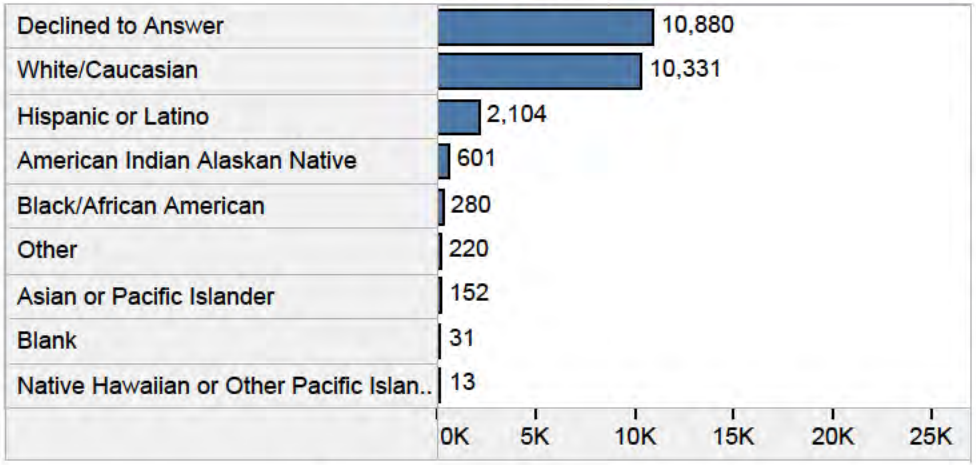
Cascade Health Alliance

05/12/2022
Devan Patel

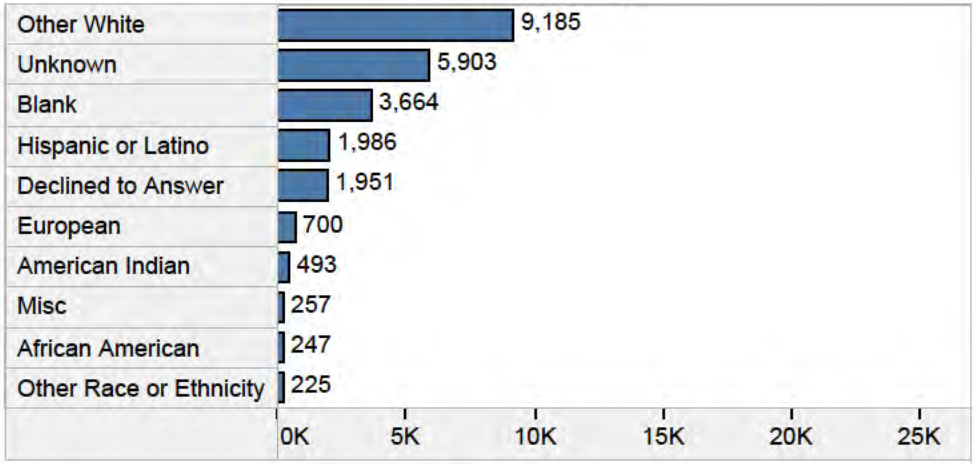
Race	Multiple values	**Ethnicity**	All	**Language**	All
City	All	**Age**	All	**Health Plan**	All

Total Members	Total Males	Total Females	Members with Disability
24,611	11,841	12,770	2,175

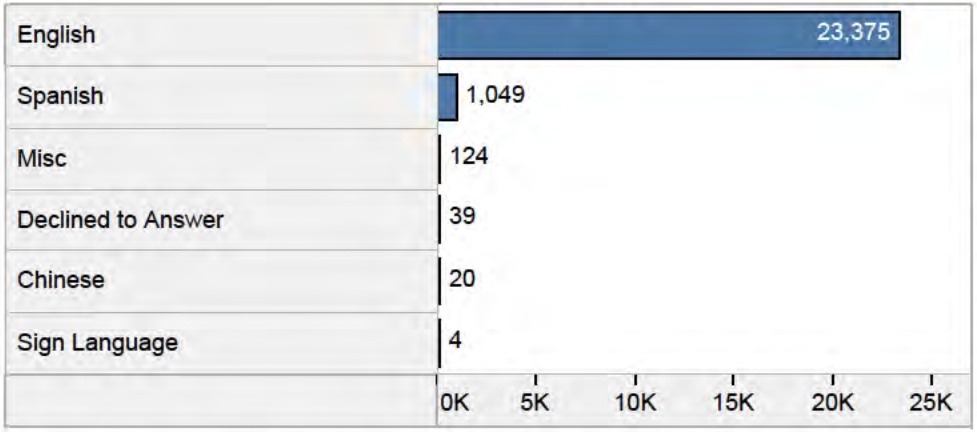
Members by Race



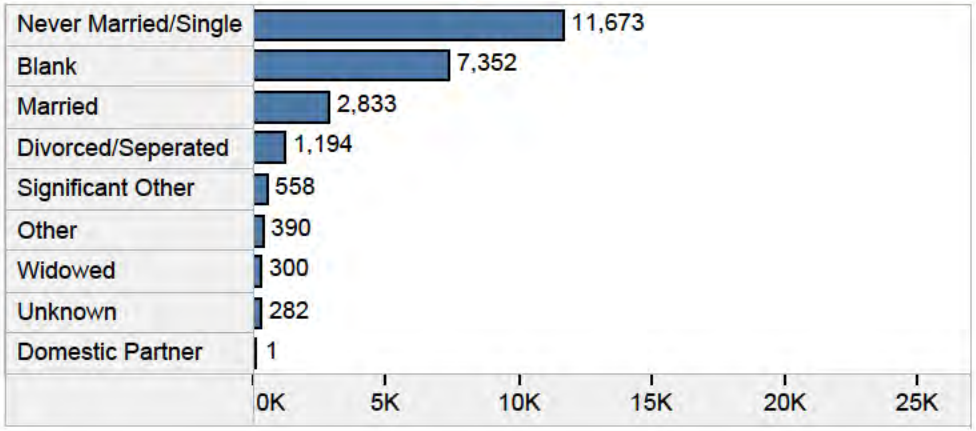
Members by Ethnicity



Members by Language



Members by Marital Status



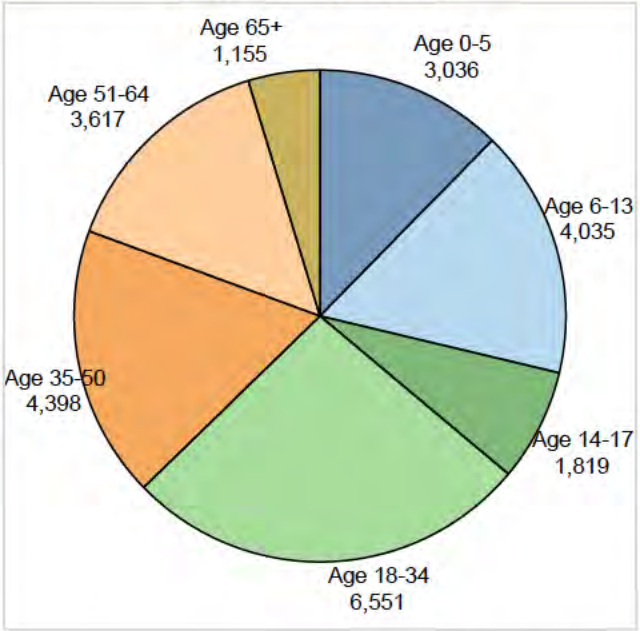
Membership: Active Members on 05/01/2022 **Updated:** 05/12/2022 **Source:** Plexis and Reliance

ACTIVE MEMBER DEMOGRAPHICS

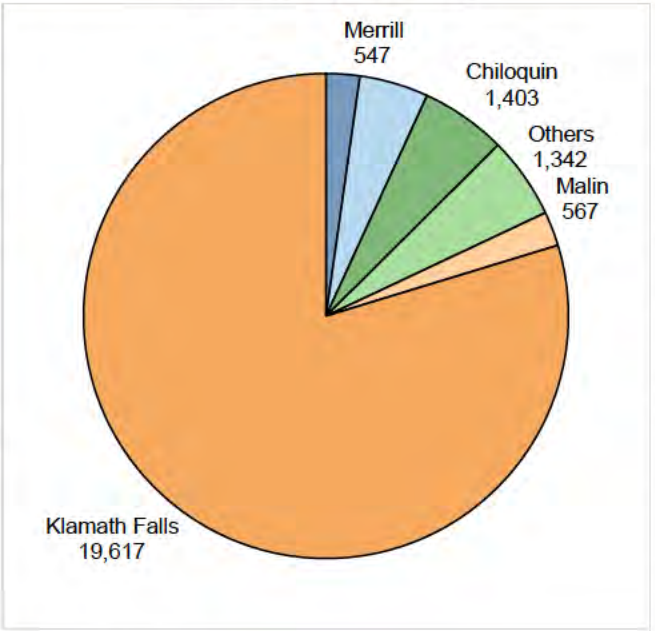
Cascade Health Alliance

05/12/2022
Devan Patel

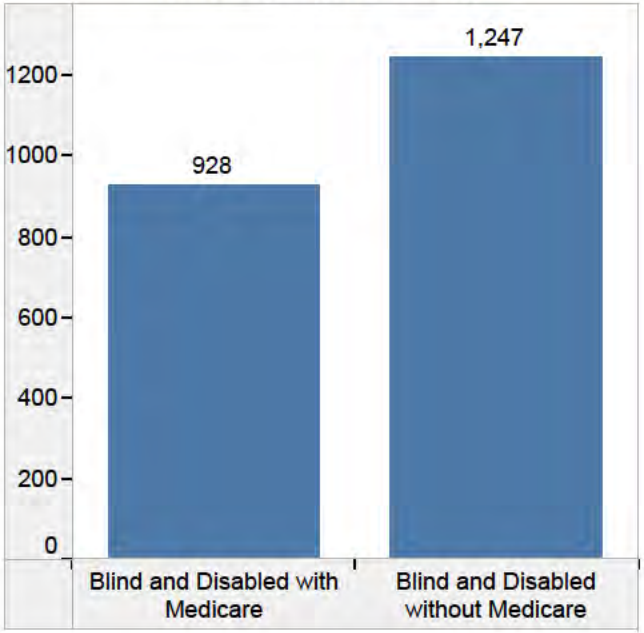
Members by Age Bin



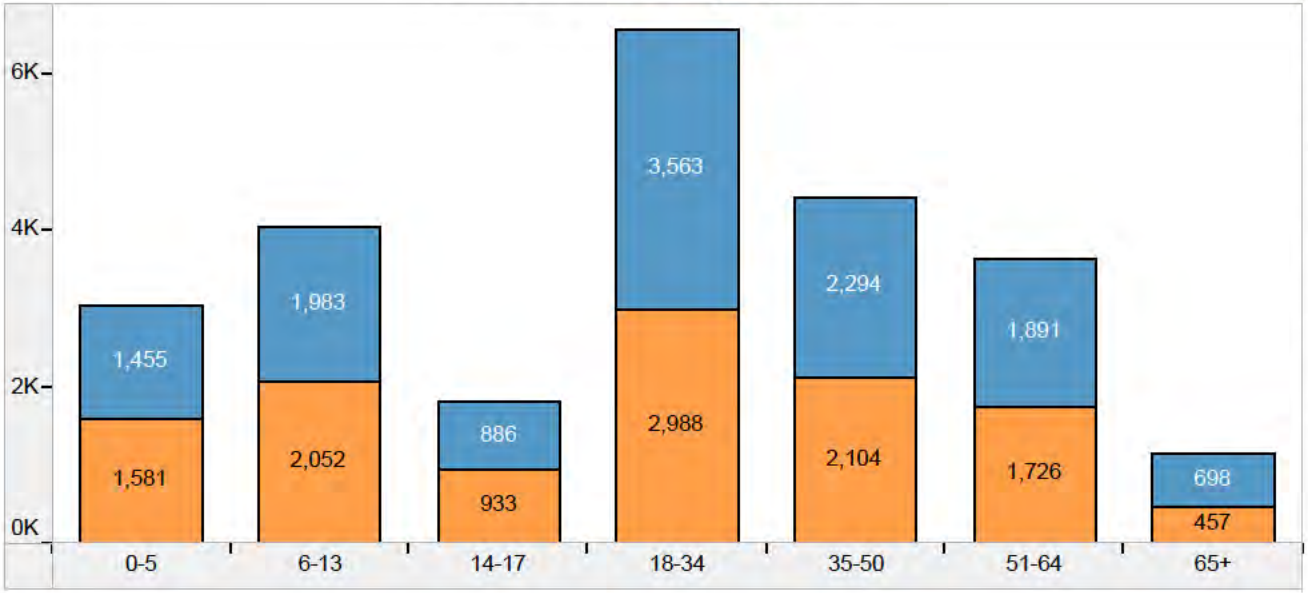
Members by Location



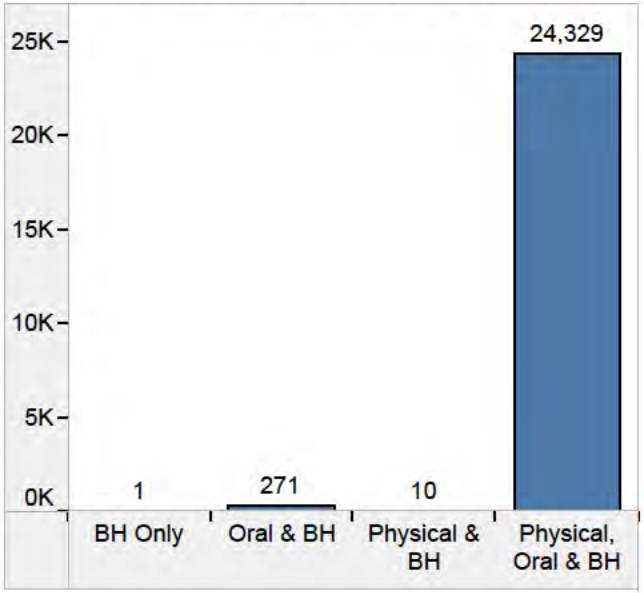
Members with Diability



Member Gender by Age Bin



Members by Benefit Plan



Membership: Active Members on 05/01/2022 **Updated:** 05/12/2022 **Source:** and Reliance

ACTIVE MEMBER DEMOGRAPHICS

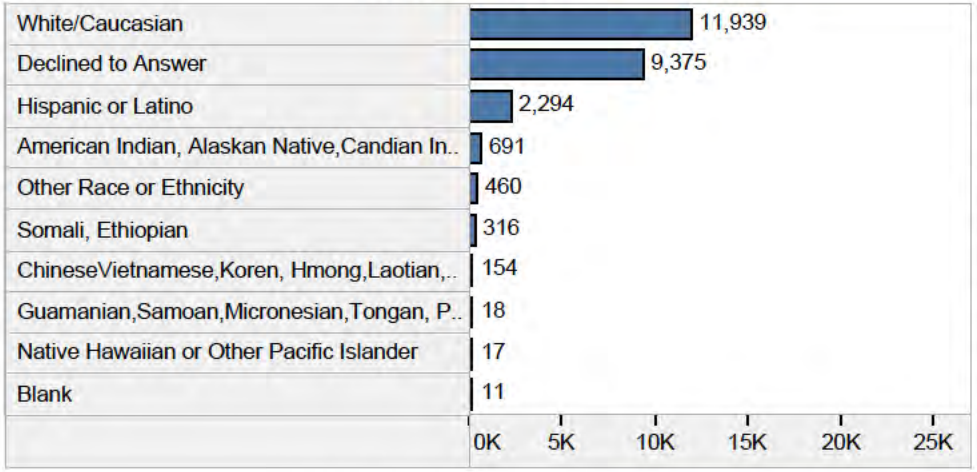
Cascade Health Alliance

10/1/2022

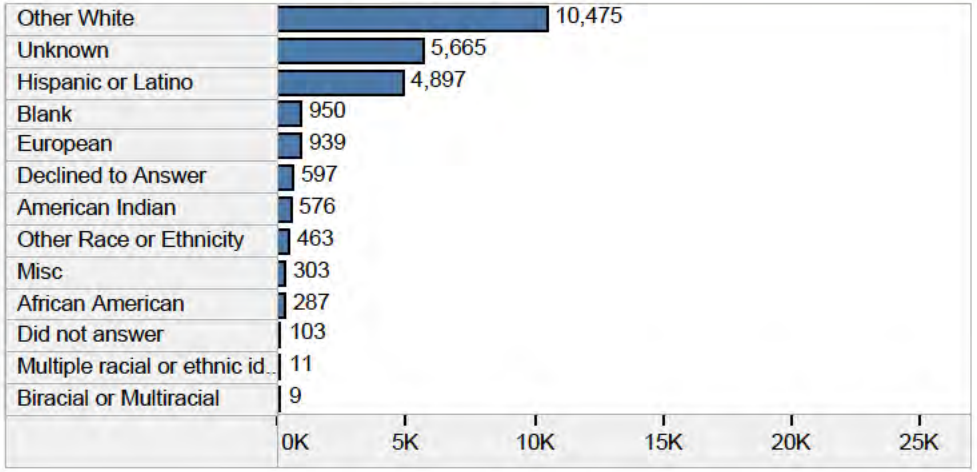
Race	All	**Ethnicity**	All	**Language**	All
City	All	**Age**	All	**Health Plan**	All

Total Members	Total Males	Total Females	Members with Disability	Dual Eligible Members
25,274	12,174	13,100	2,228	2,108

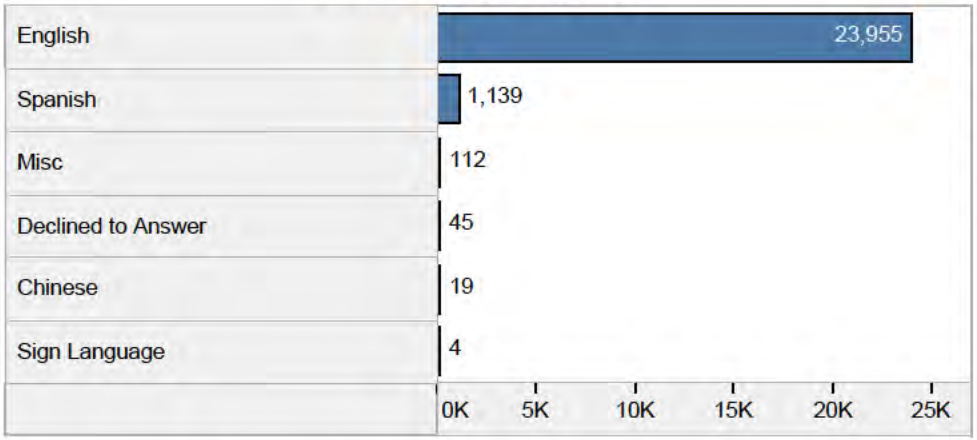
Members by Race



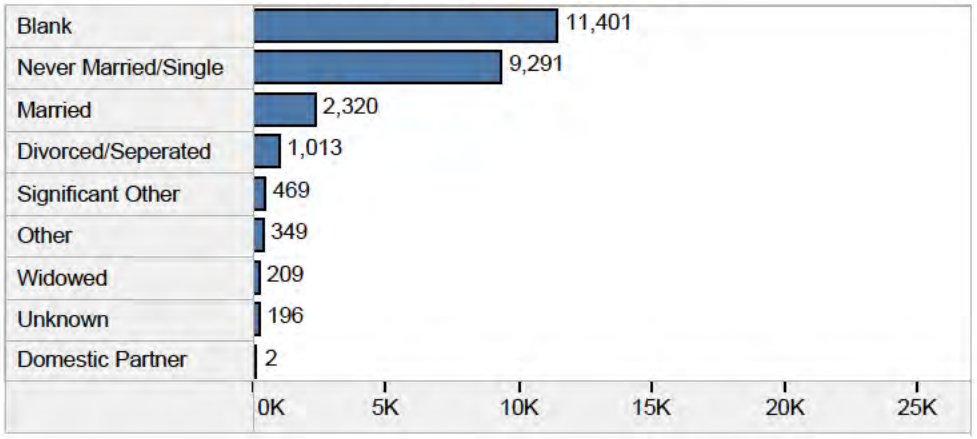
Members by Ethnicity



Members by Language



Members by Marital Status



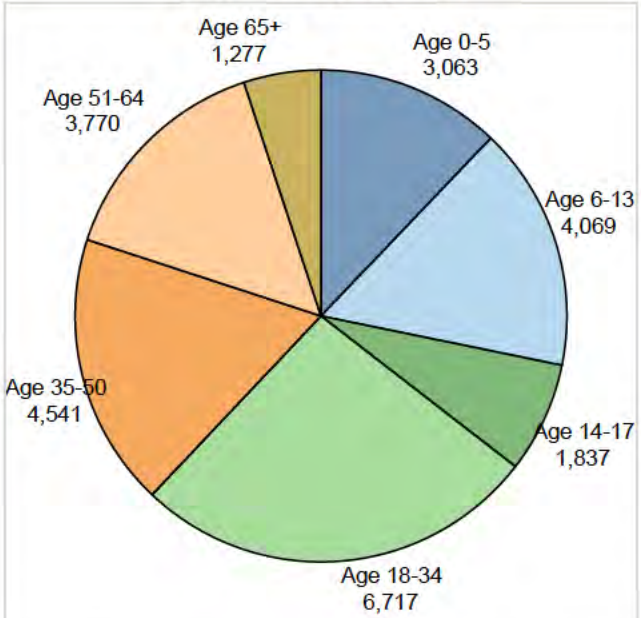
Membership: Active Members on 9/30/2022 **Updated:** 10/1/2022 **Source:** and Reliance

ACTIVE MEMBER DEMOGRAPHICS

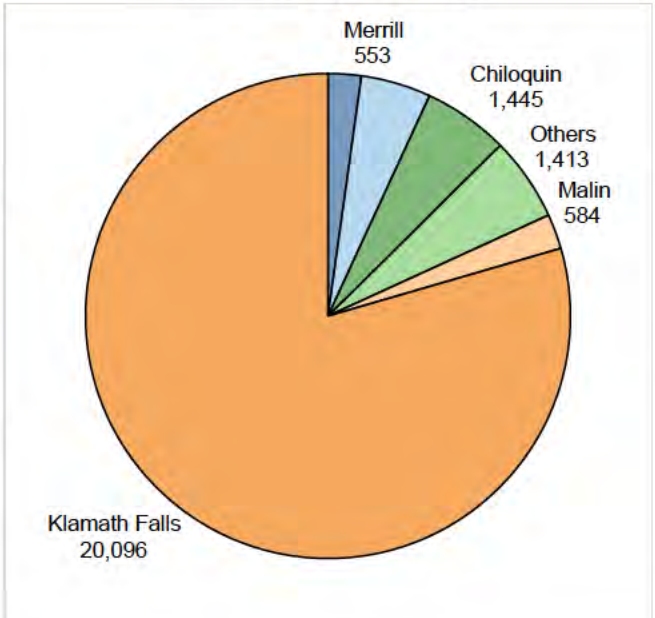
Cascade Health Alliance

10/1/2022

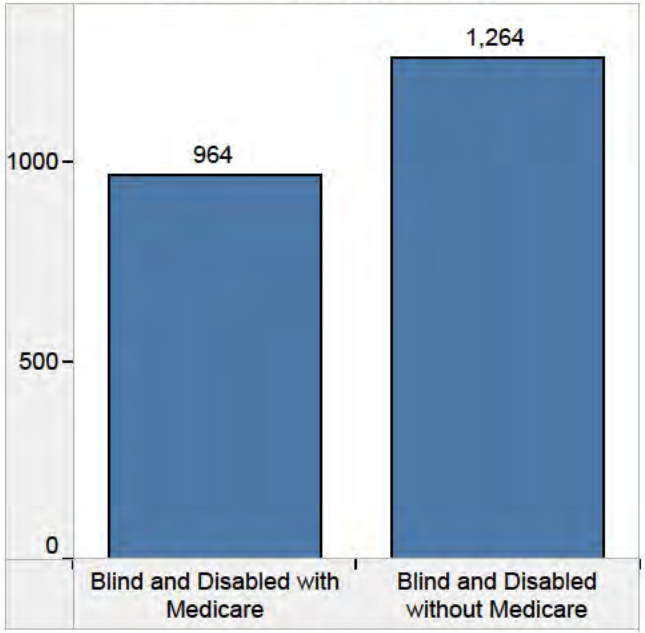
Members by Age Bin



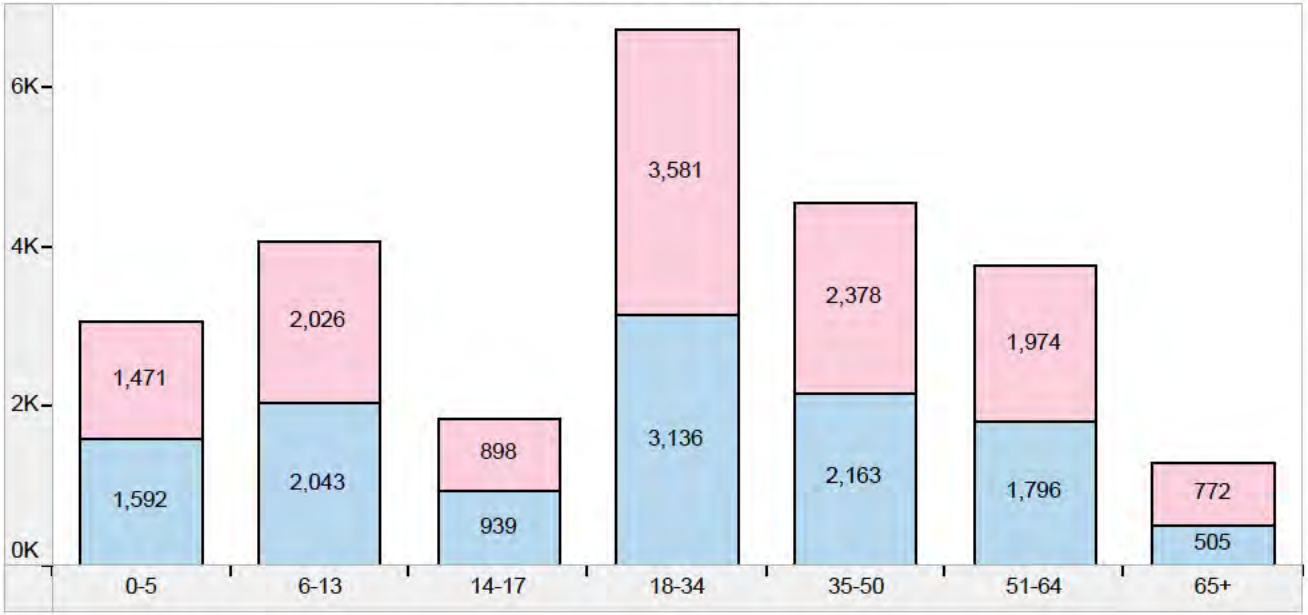
Members by Location



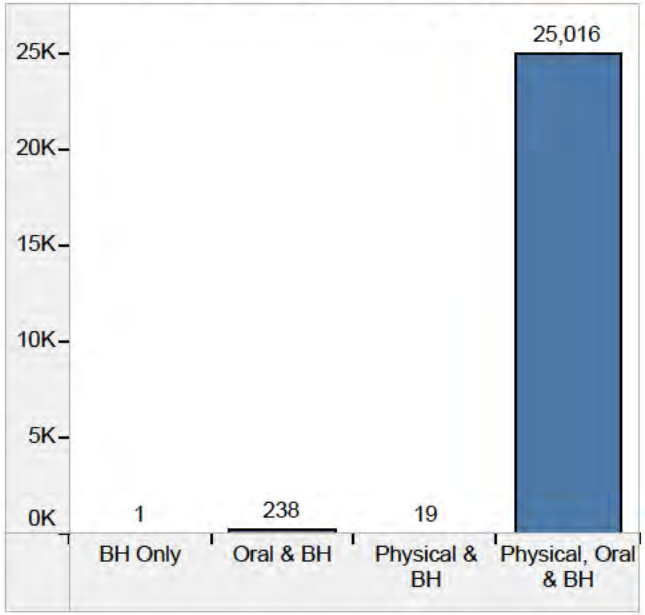
Members with Disability



Member Gender by Age Bin



Members by Benefit Plan



Membership: Active Members on 9/30/2022 **Updated:** 10/1/2022 **Source:** and Reliance

OHA Project #61

ACTIVE MEMBER DEMOGRAPHICS

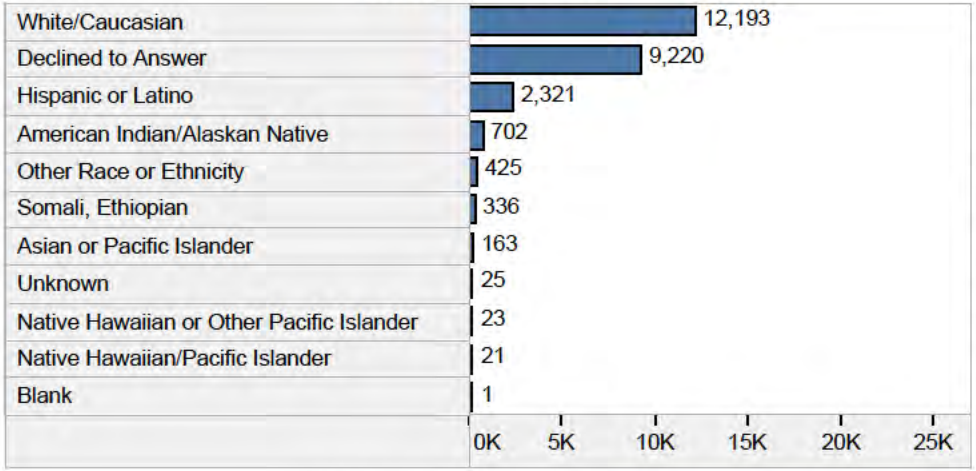
Cascade Health Alliance

11/1/2022

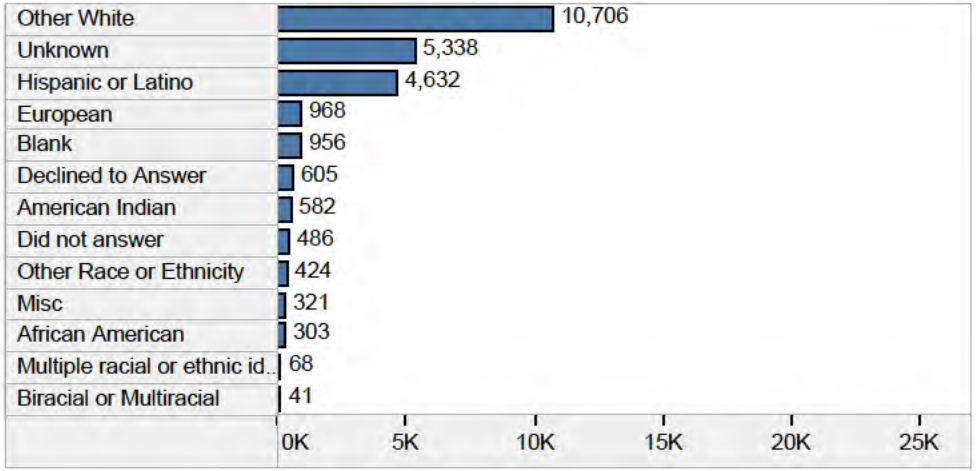
Race	All	**Ethnicity**	All	**Language**	All
City	All	**Age**	All	**Health Plan**	All

Total Members	Total Males	Total Females	Members with Disability	Dual Eligible Members
25,429	12,252	13,177	2,238	2,143

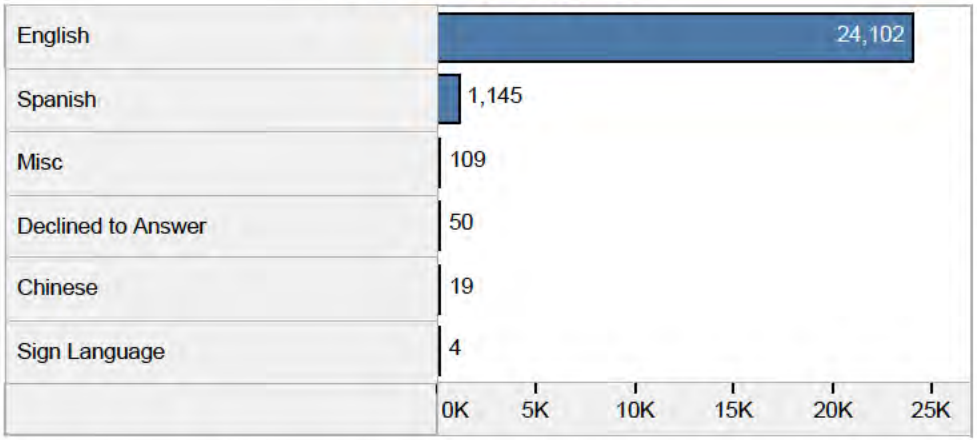
Members by Race



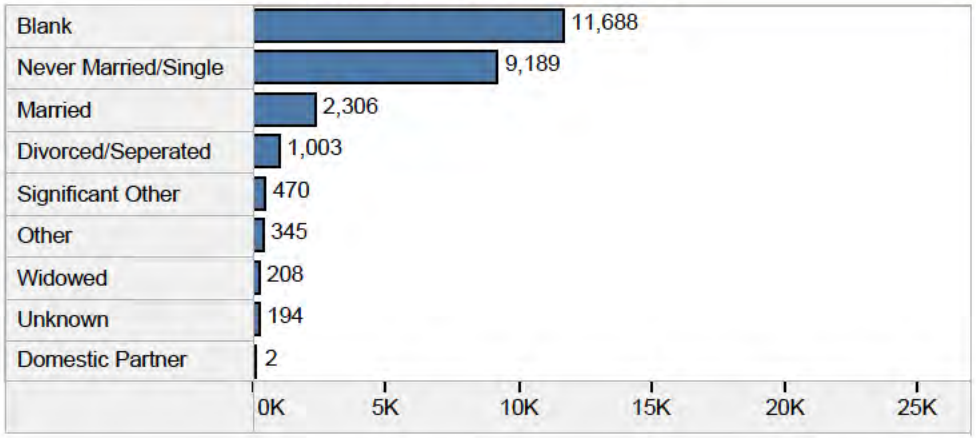
Members by Ethnicity



Members by Language



Members by Marital Status



Membership: Active Members on 10/31/2022 **Updated:** 11/1/2022 **Source:** and Reliance

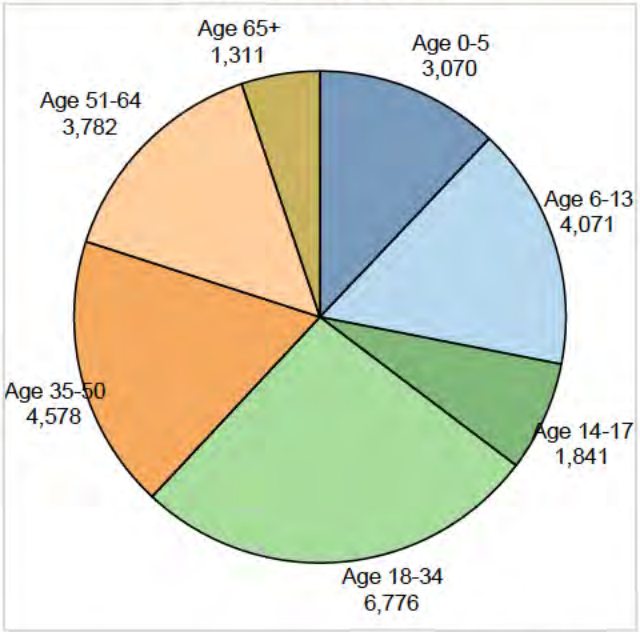
 OHA Project #61

ACTIVE MEMBER DEMOGRAPHICS

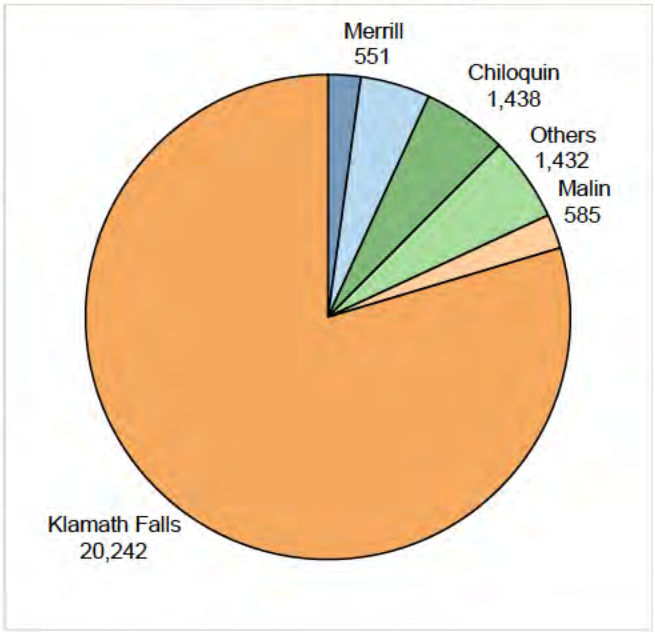
Cascade Health Alliance

11/1/2022

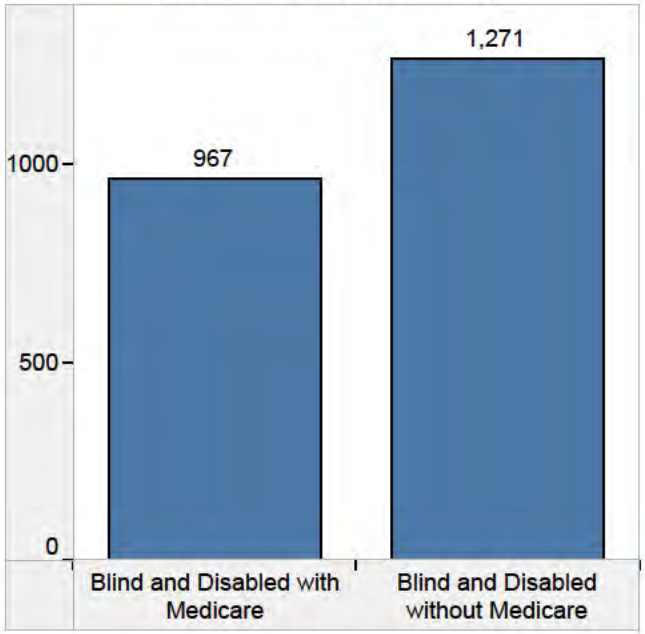
Members by Age Bin



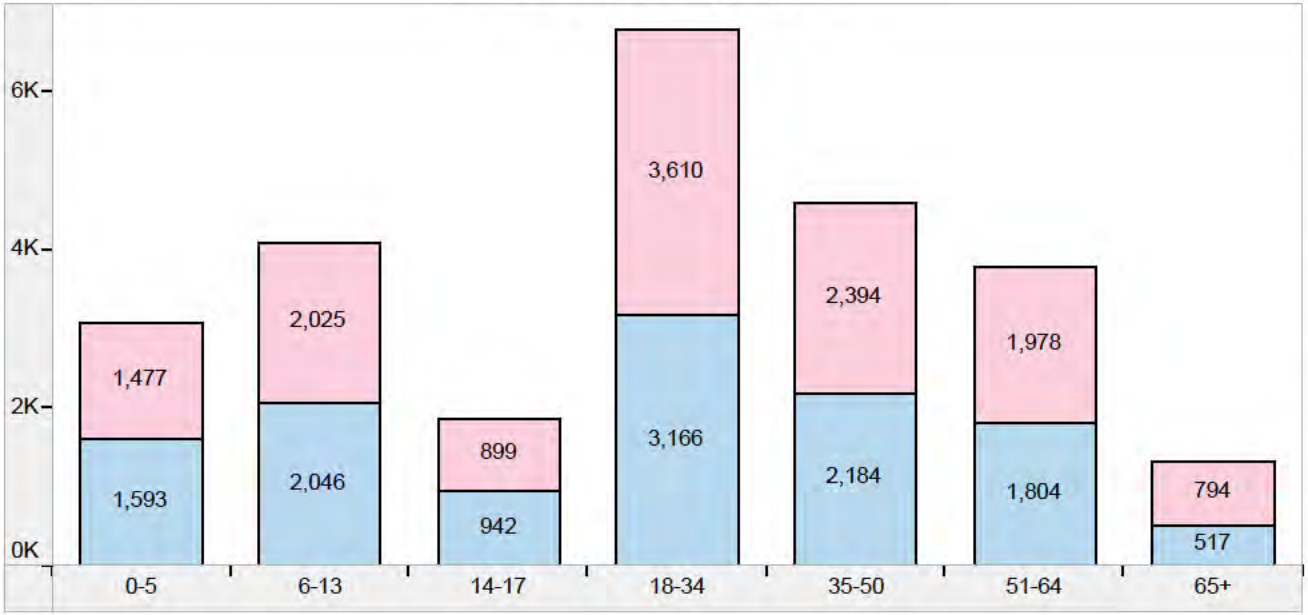
Members by Location



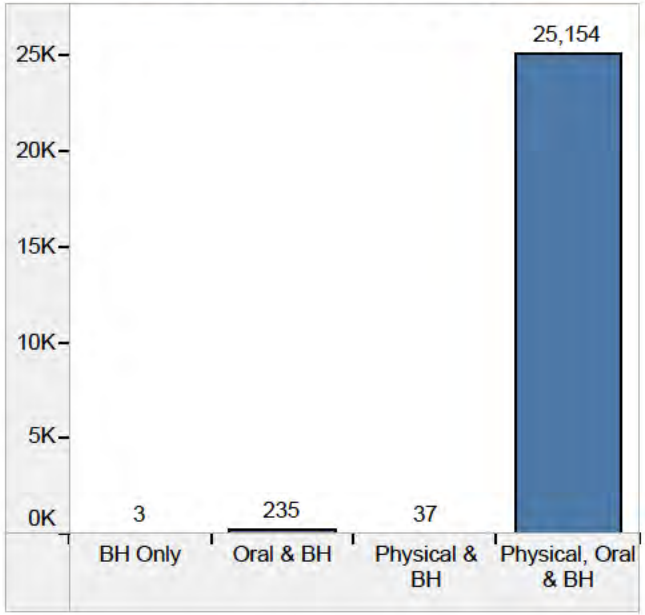
Members with Disability



Member Gender by Age Bin



Members by Benefit Plan



Membership: Active Members on 10/31/2022 **Updated:** 11/1/2022 **Source:** and Reliance

OHA Project #61

ACTIVE MEMBER DEMOGRAPHICS

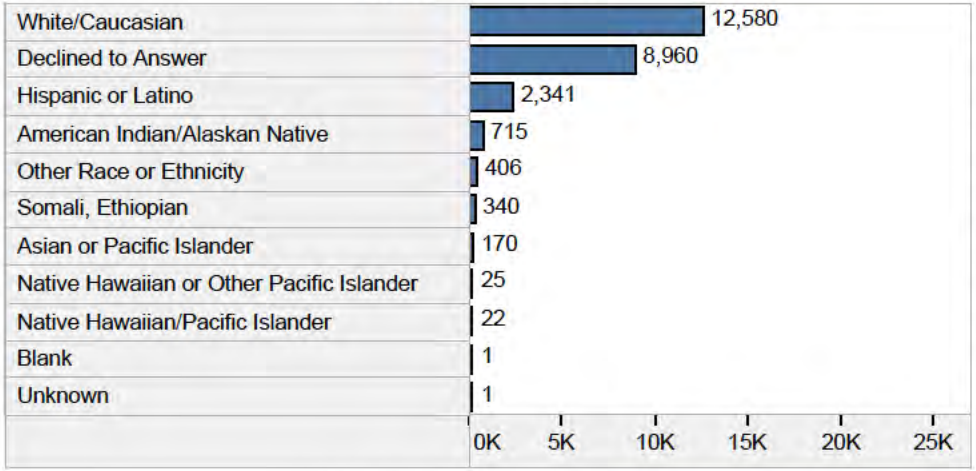
Cascade Health Alliance

12/14/2022

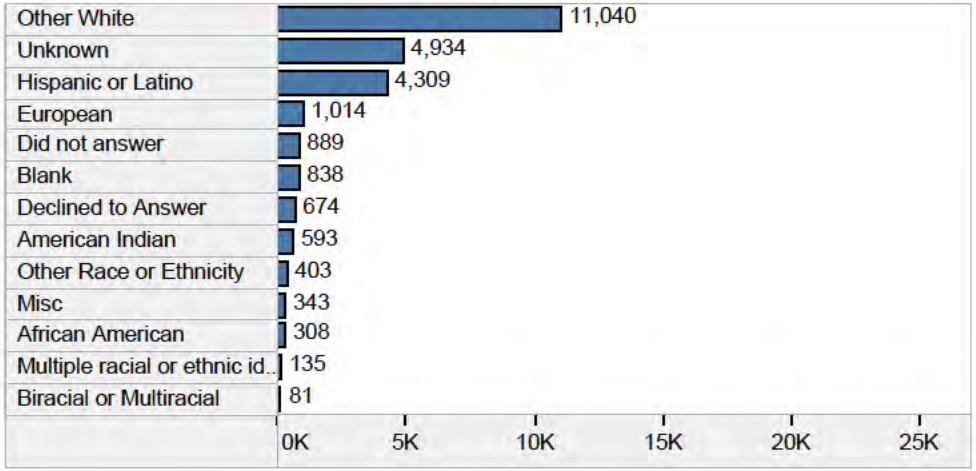
Race	All	**Ethnicity**	All	**Language**	All
City	All	**Age**	All	**Health Plan**	All

Total Members	Total Males	Total Females	Members with Disability	Dual Eligible Members
25,560	12,324	13,236	2,245	2,166

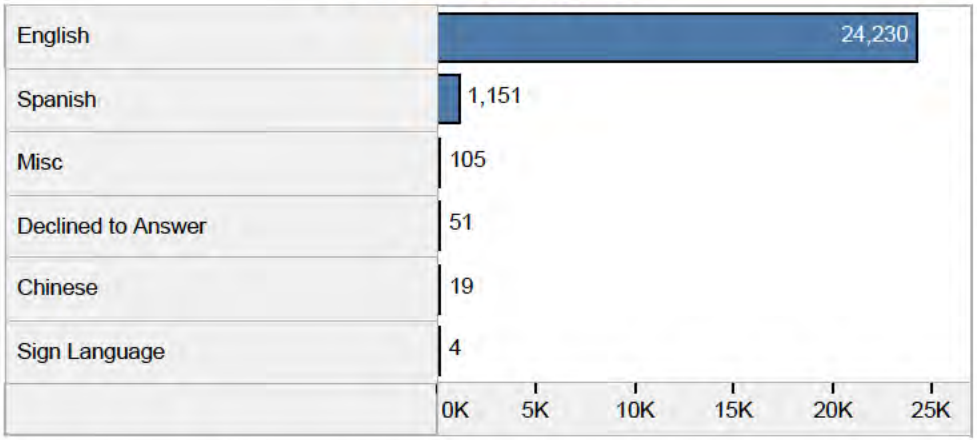
Members by Race



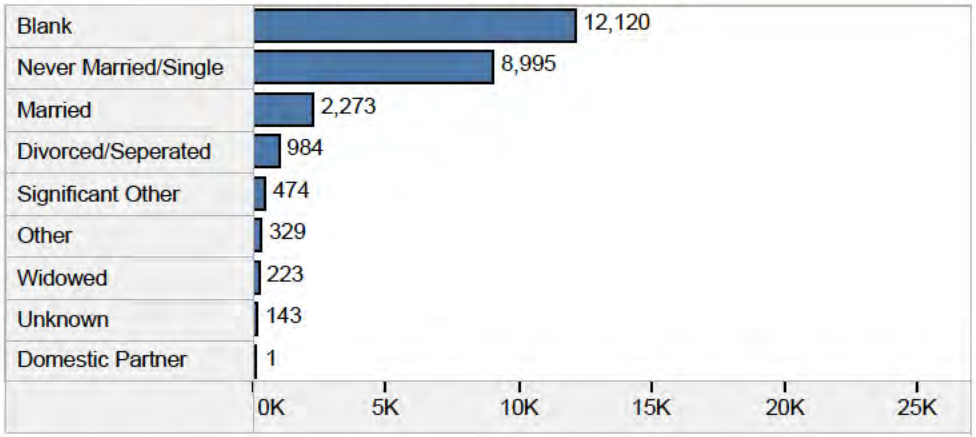
Members by Ethnicity



Members by Language



Members by Marital Status



Membership: Active Members on 11/30/2022 **Updated:** 12/14/2022 **Source:** and Reliance

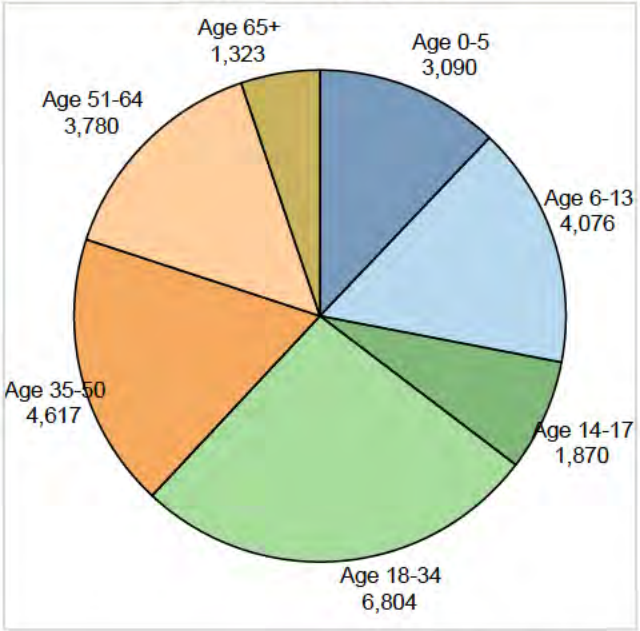
OHA Project #61

ACTIVE MEMBER DEMOGRAPHICS

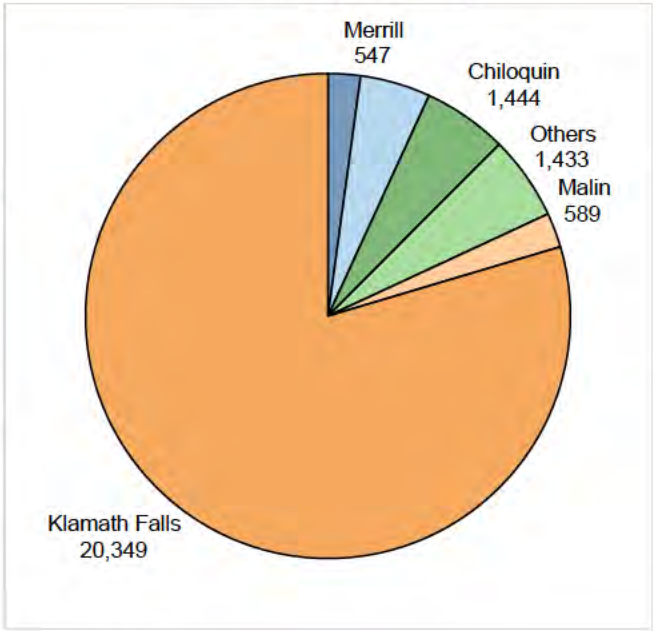
Cascade Health Alliance

12/14/2022

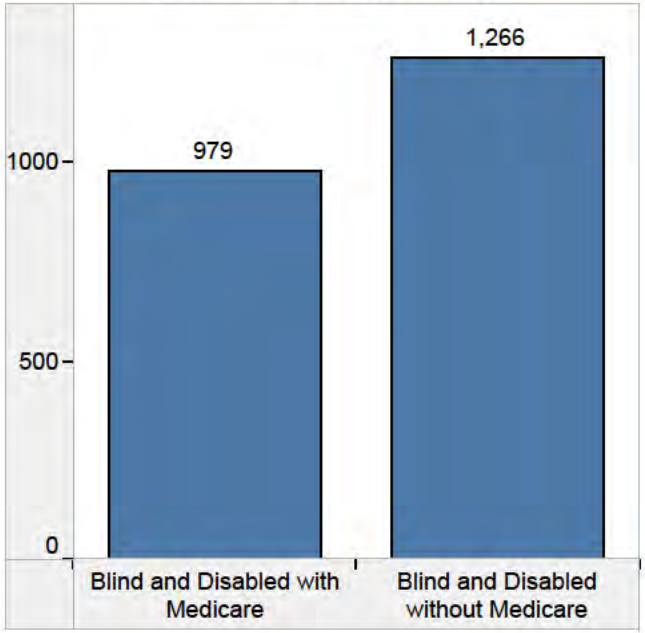
Members by Age Bin



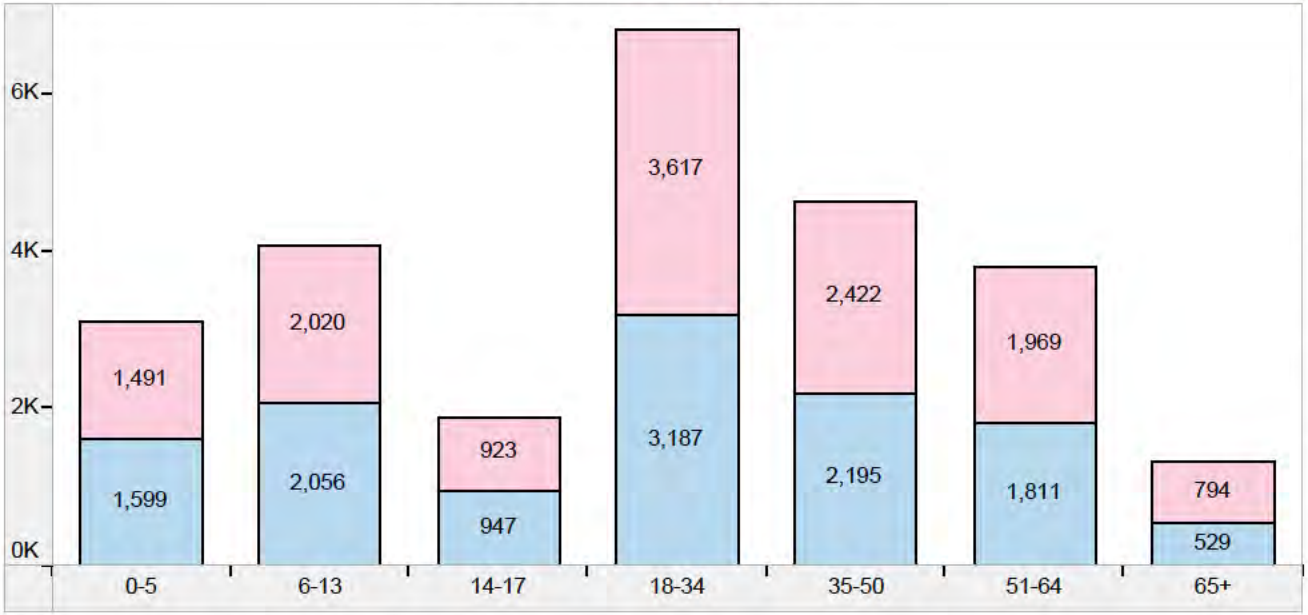
Members by Location



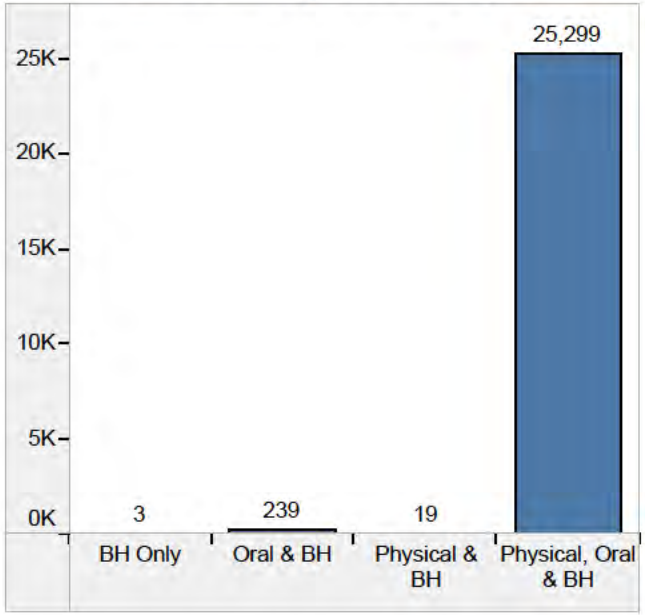
Members with Disability



Member Gender by Age Bin



Members by Benefit Plan



Membership: Active Members on 11/30/2022 **Updated:** 12/14/2022 **Source:** I and Reliance

ACTIVE MEMBER DEMOGRAPHICS

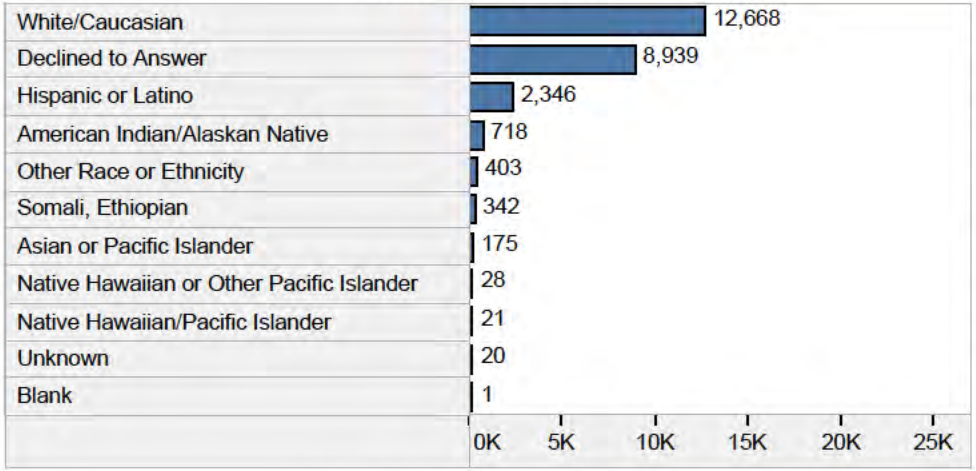
Cascade Health Alliance

1/1/2023

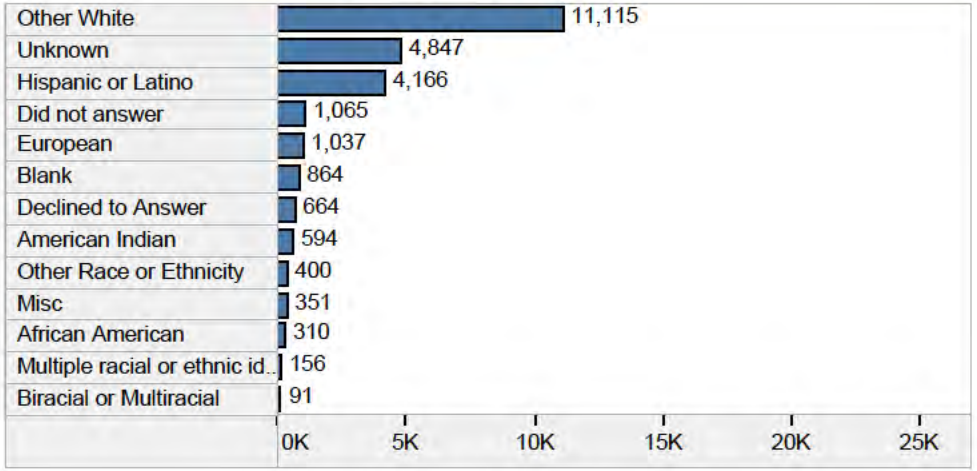
Race	All	**Ethnicity**	All	**Language**	All
City	All	**Age**	All	**Health Plan**	All

Total Members	Total Males	Total Females	Members with Disability	Dual Eligible Members
25,660	12,384	13,276	2,145	2,184

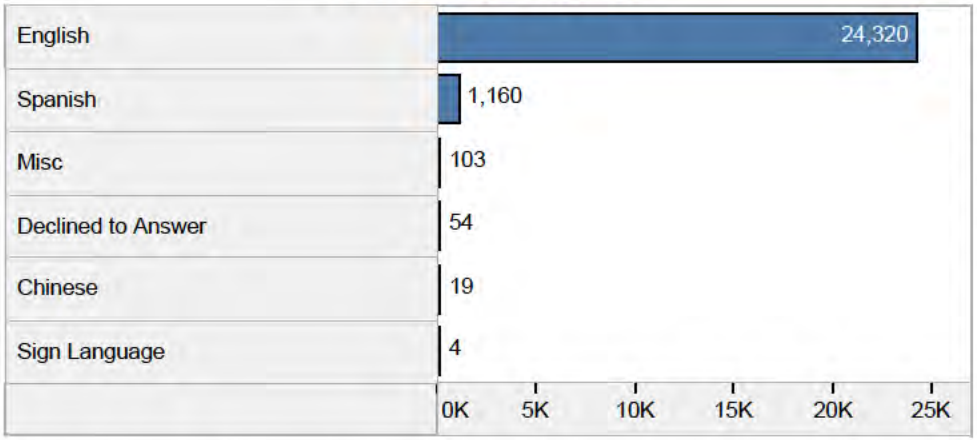
Members by Race



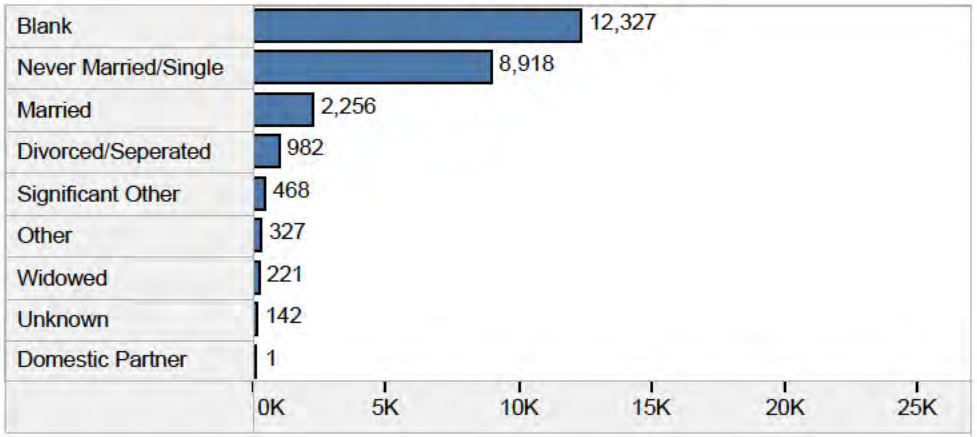
Members by Ethnicity



Members by Language



Members by Marital Status



Membership: Active Members on 12/31/2022 **Updated:** 1/1/2023 **Source:** and Reliance

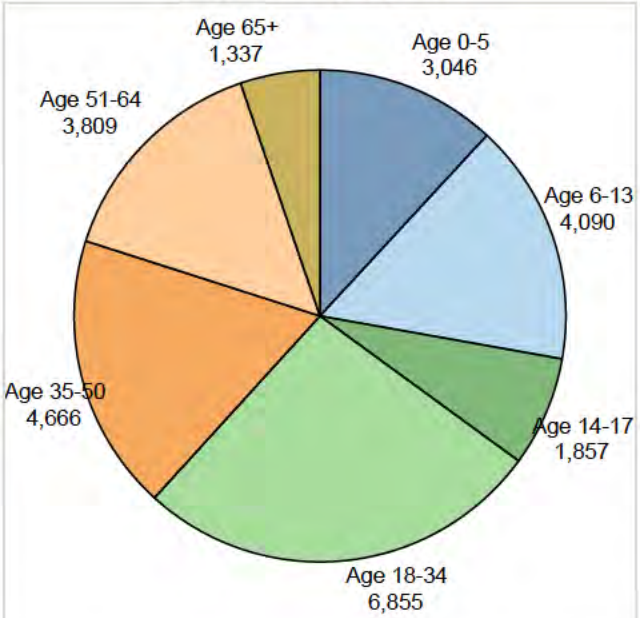
OHA Project #61

ACTIVE MEMBER DEMOGRAPHICS

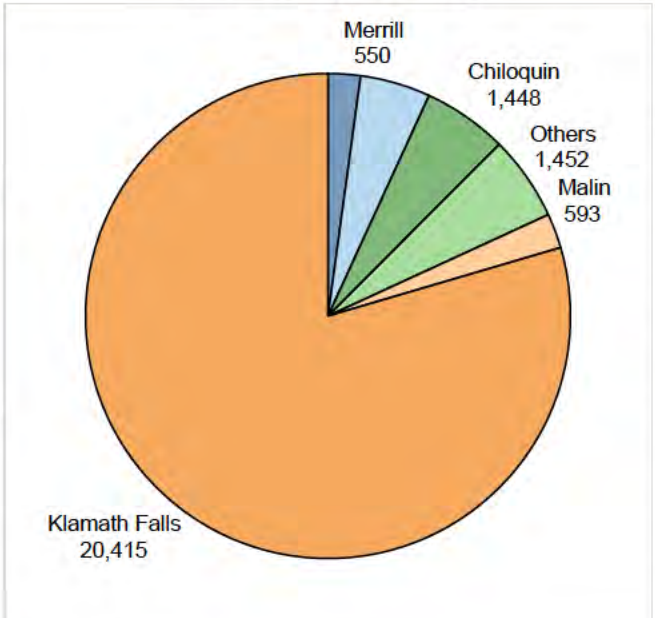
Cascade Health Alliance

1/1/2023

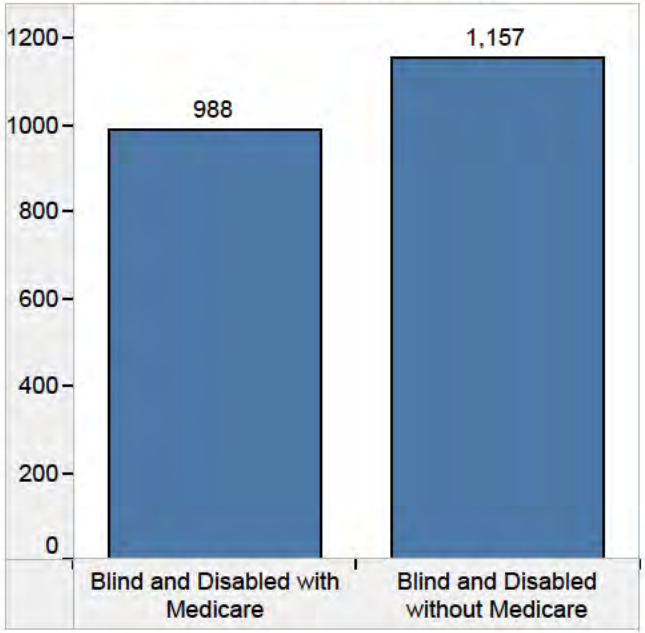
Members by Age Bin



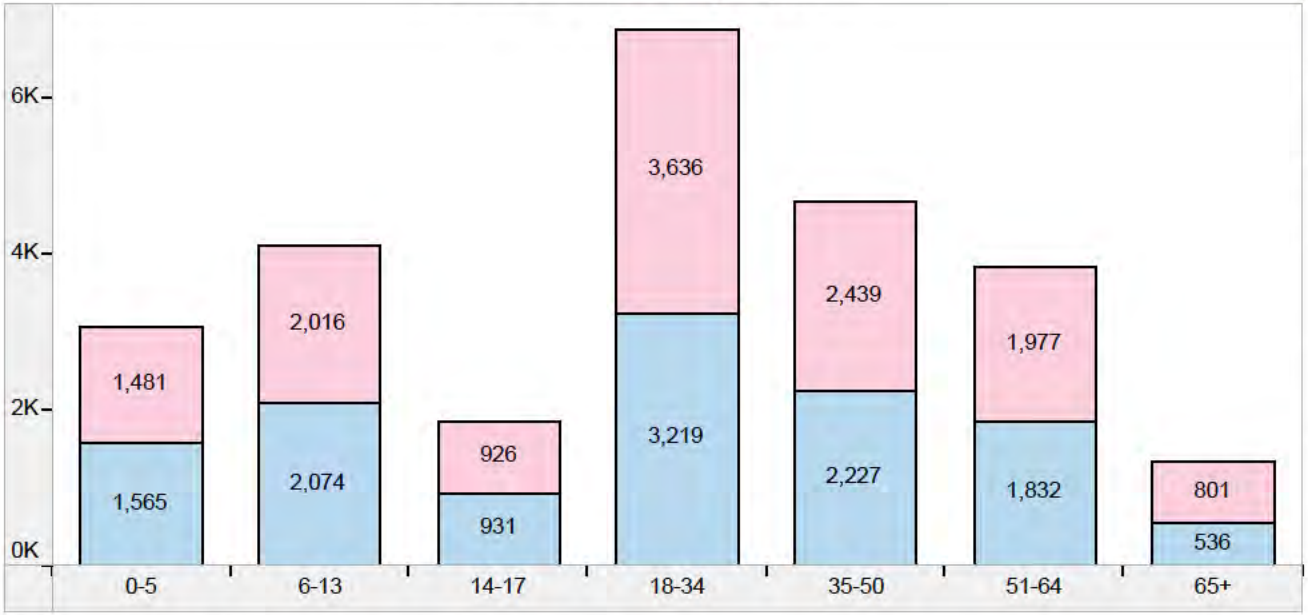
Members by Location



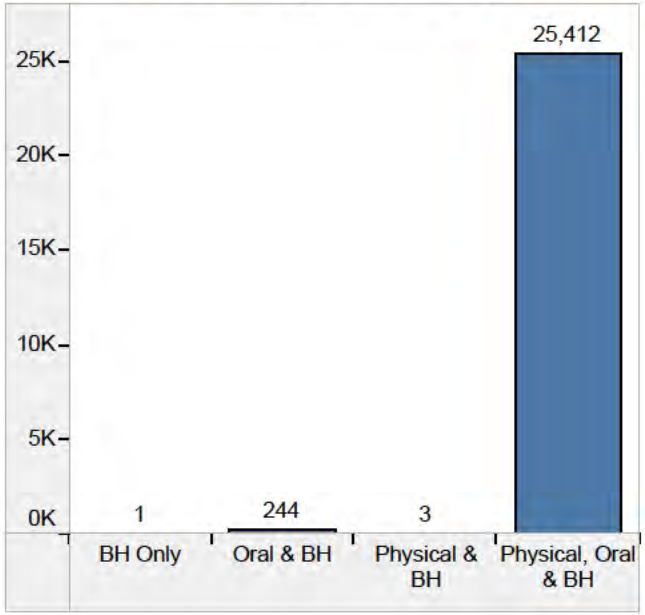
Members with Disability



Member Gender by Age Bin



Members by Benefit Plan



Membership: Active Members on 12/31/2022 **Updated:** 1/1/2023 **Source:** and Reliance

OHA Project #61

ACTIVE MEMBER DEMOGRAPHICS

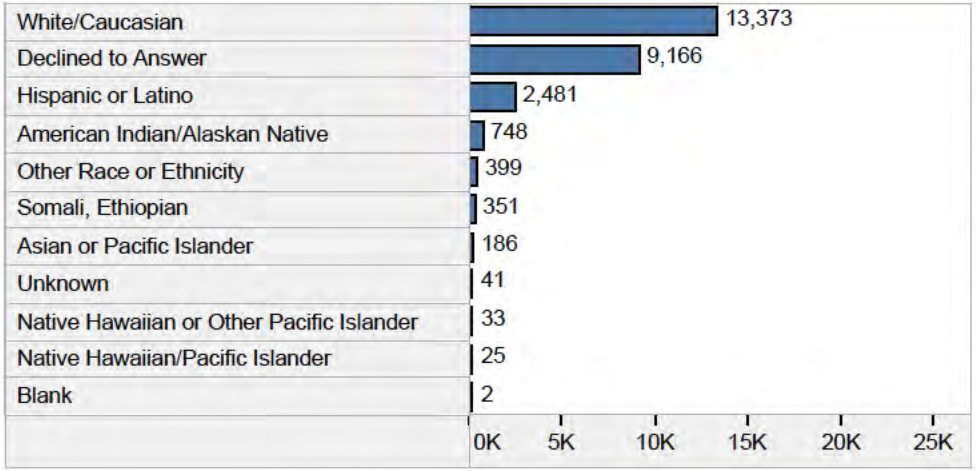
Cascade Health Alliance

2/1/2023

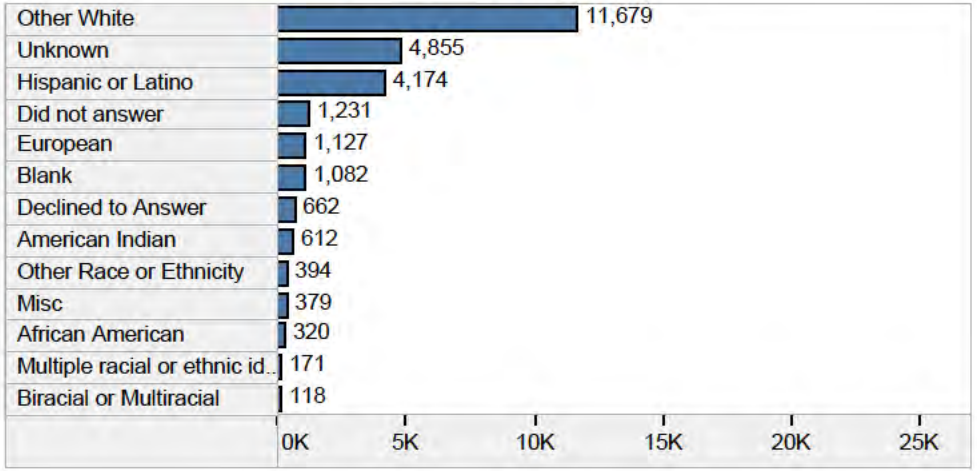
Race	All	**Ethnicity**	All	**Language**	All
City	All	**Age**	All	**Health Plan**	All

Total Members	Total Males	Total Females	Members with Disability	Dual Eligible Members
26,804	12,897	13,907	2,201	2,236

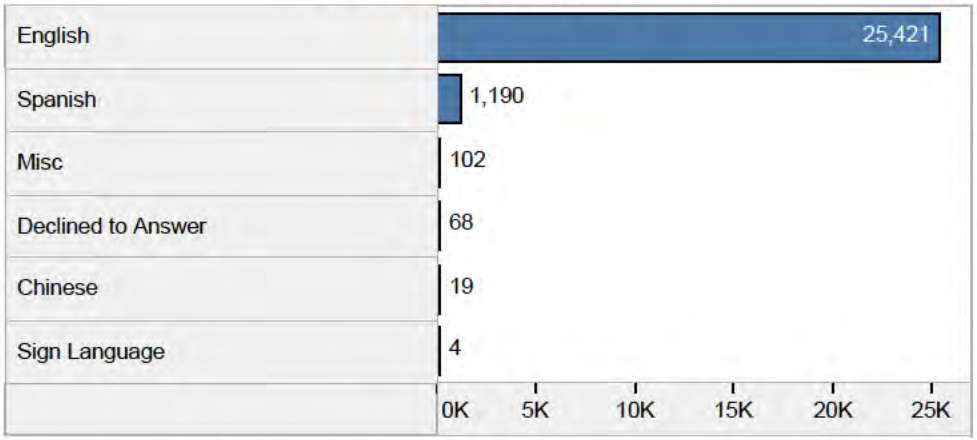
Members by Race



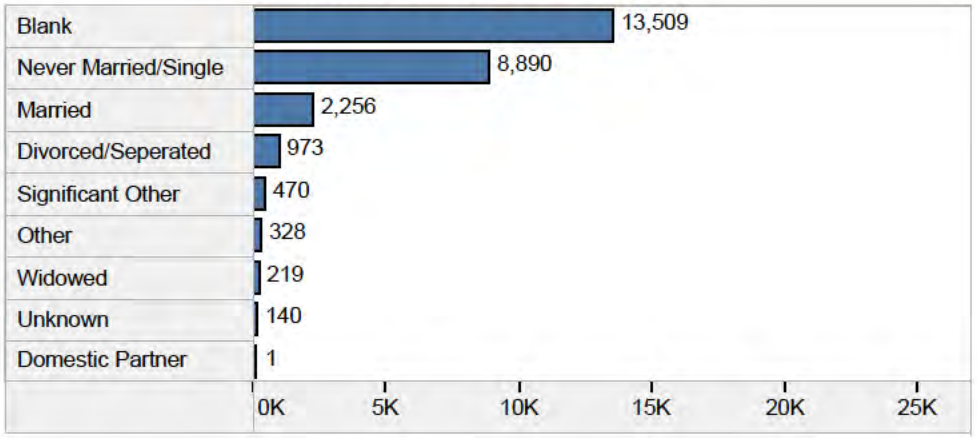
Members by Ethnicity



Members by Language



Members by Marital Status



Membership: Active Members on 1/31/2023 **Updated:** 2/1/2023 **Source:** I and Reliance

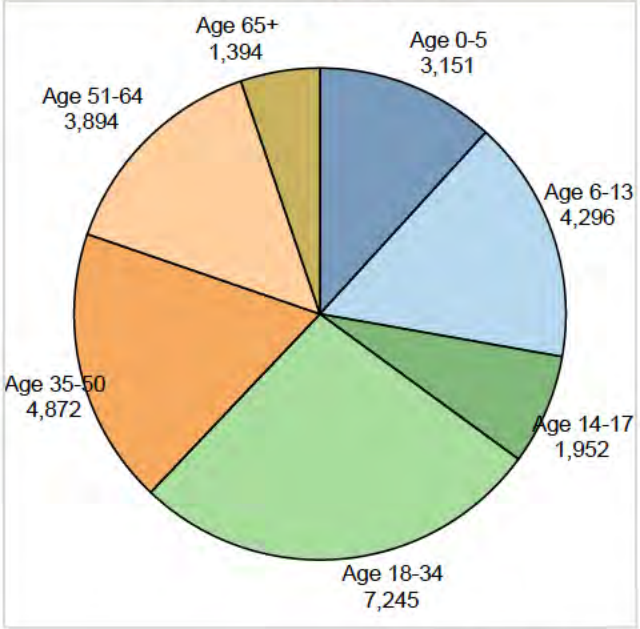
OHA Project #61

ACTIVE MEMBER DEMOGRAPHICS

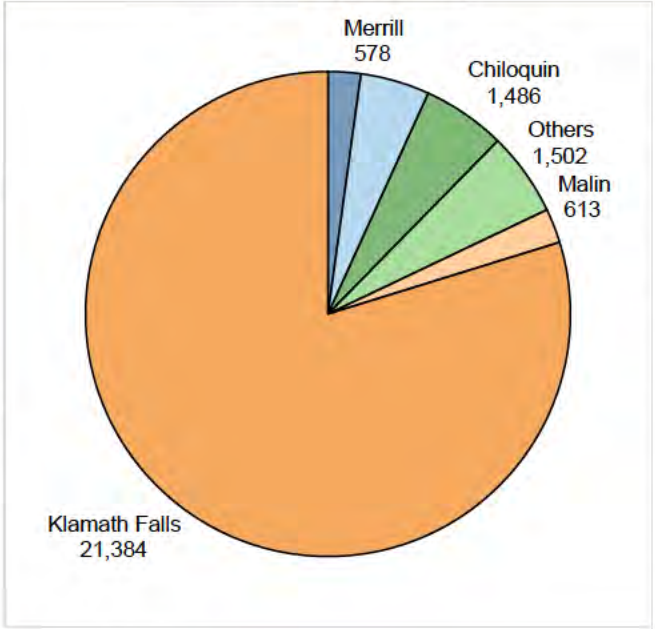
Cascade Health Alliance

2/1/2023

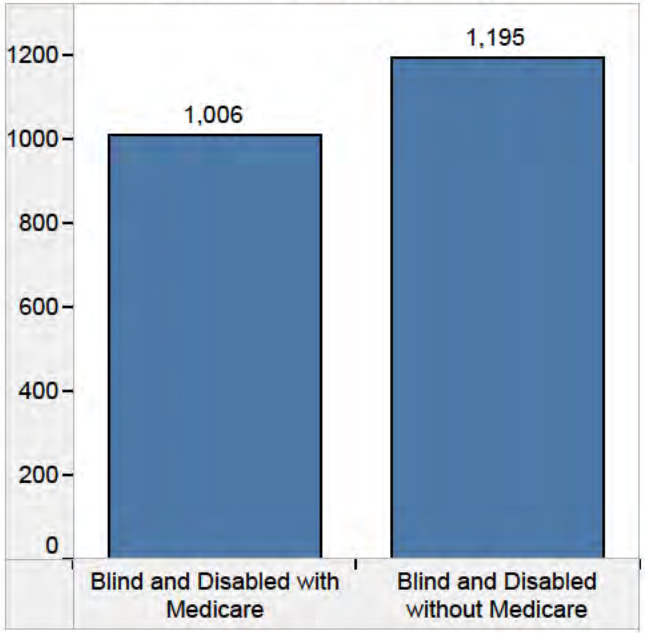
Members by Age Bin



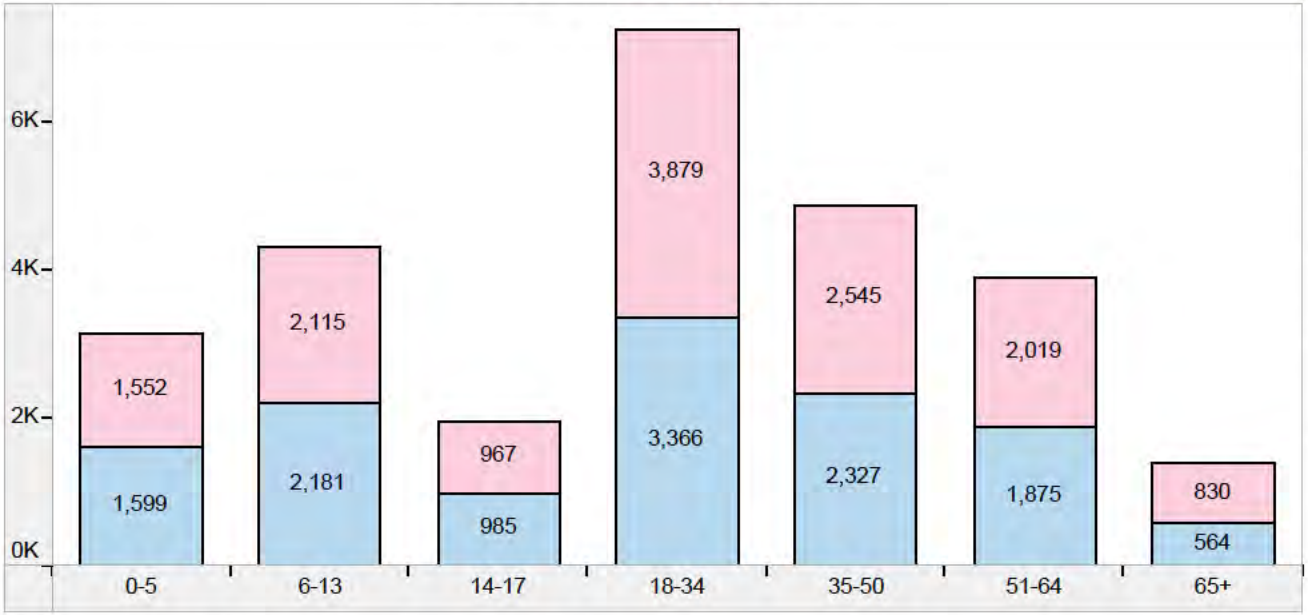
Members by Location



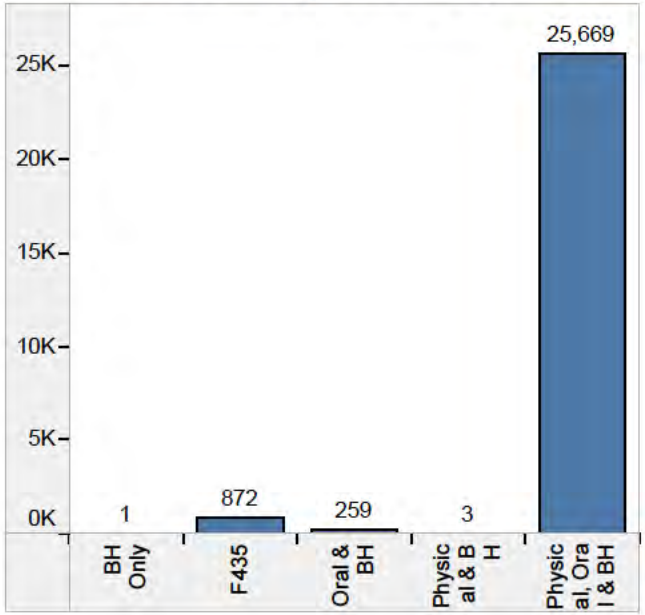
Members with Disability



Member Gender by Age Bin



Members by Benefit Plan



Membership: Active Members on 1/31/2023 **Updated:** 2/1/2023 **Source:** and Reliance

OHA Project #61

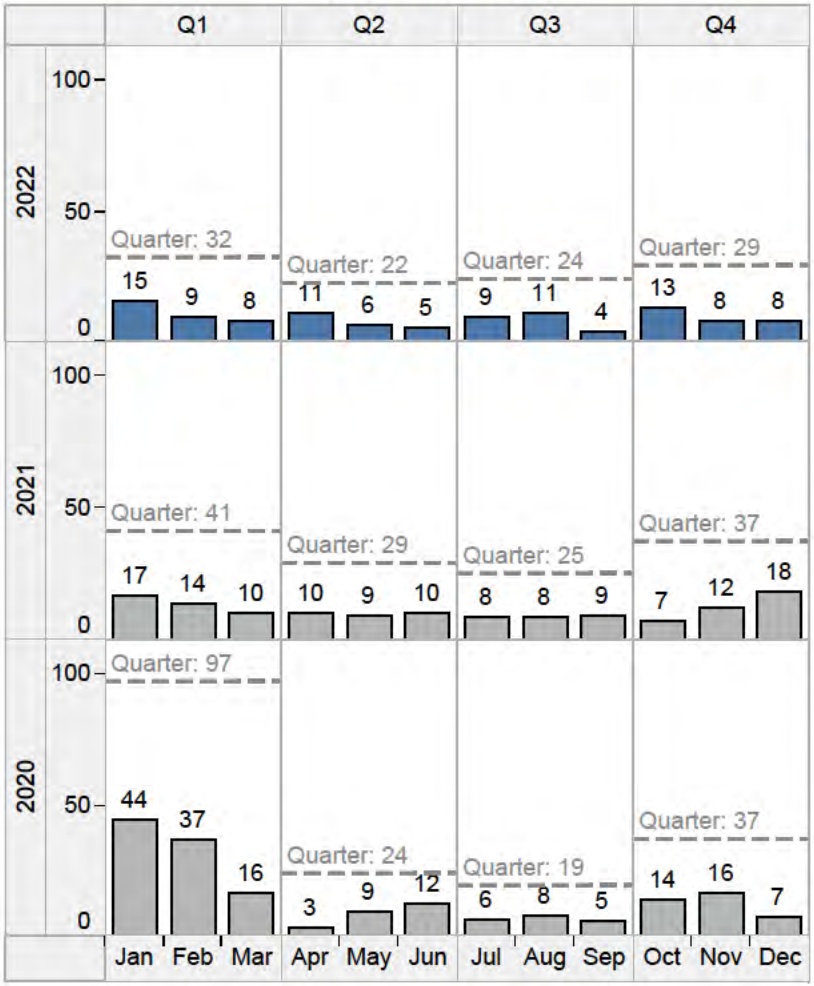
GRIEVANCES YEAR OVER YEAR

Cascade Health Alliance

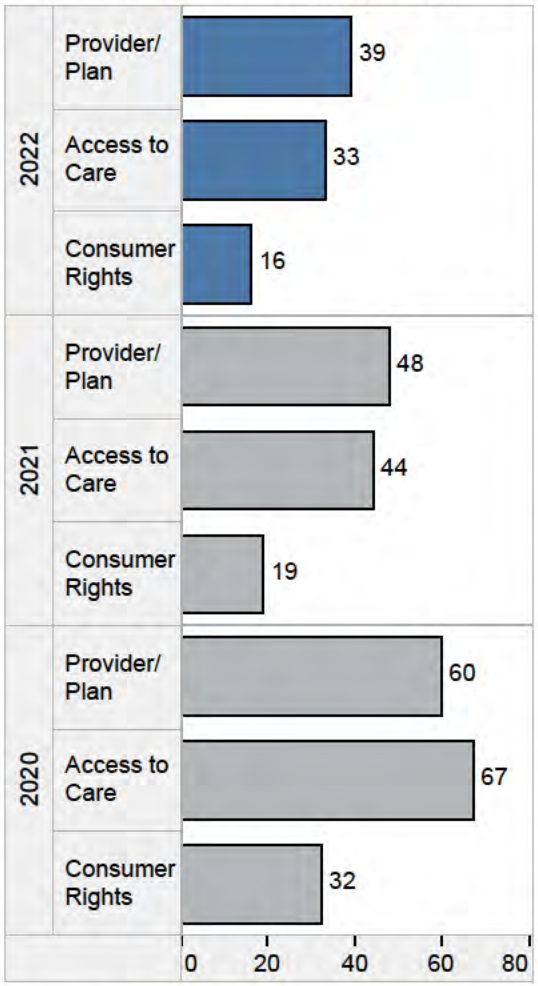
2/7/2023
Danielle Sherman

Service Type All

Grievances by Month



Top 3 Grievance Categories by Year



Grievances by Service Type

	2020	2021	2022
1) DME	1%	1%	1%
4) Hospital		2%	2%
5) ED	1%	1%	2%
8) Pharmacy	1%	4%	3%
9) Dental	52%	30%	30%
10) MH	3%		1%
11) Pain Mgt	1%	1%	1%
12) SUD	1%		
13) Specialty	2%	4%	4%
15) PCP	24%	26%	21%
16) Outpatient	1%		
17) Other	2%	20%	23%
19) Imaging	1%		
20) NEMT	8%	9%	9%
21) Vision	1%	1%	1%
22) CCO/Plan	3%	2%	2%

Average Resolution (Days)

2020				2021				2022			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1.41	0.33	7.11	2.16	2.22	4.55	8.36	1.38	4.59	4.00	3.63	3.62

Grievance Activity: 1/1/2020 - 12/31/2022 Extracted: 2/7/2023 **Source:** and Compliance

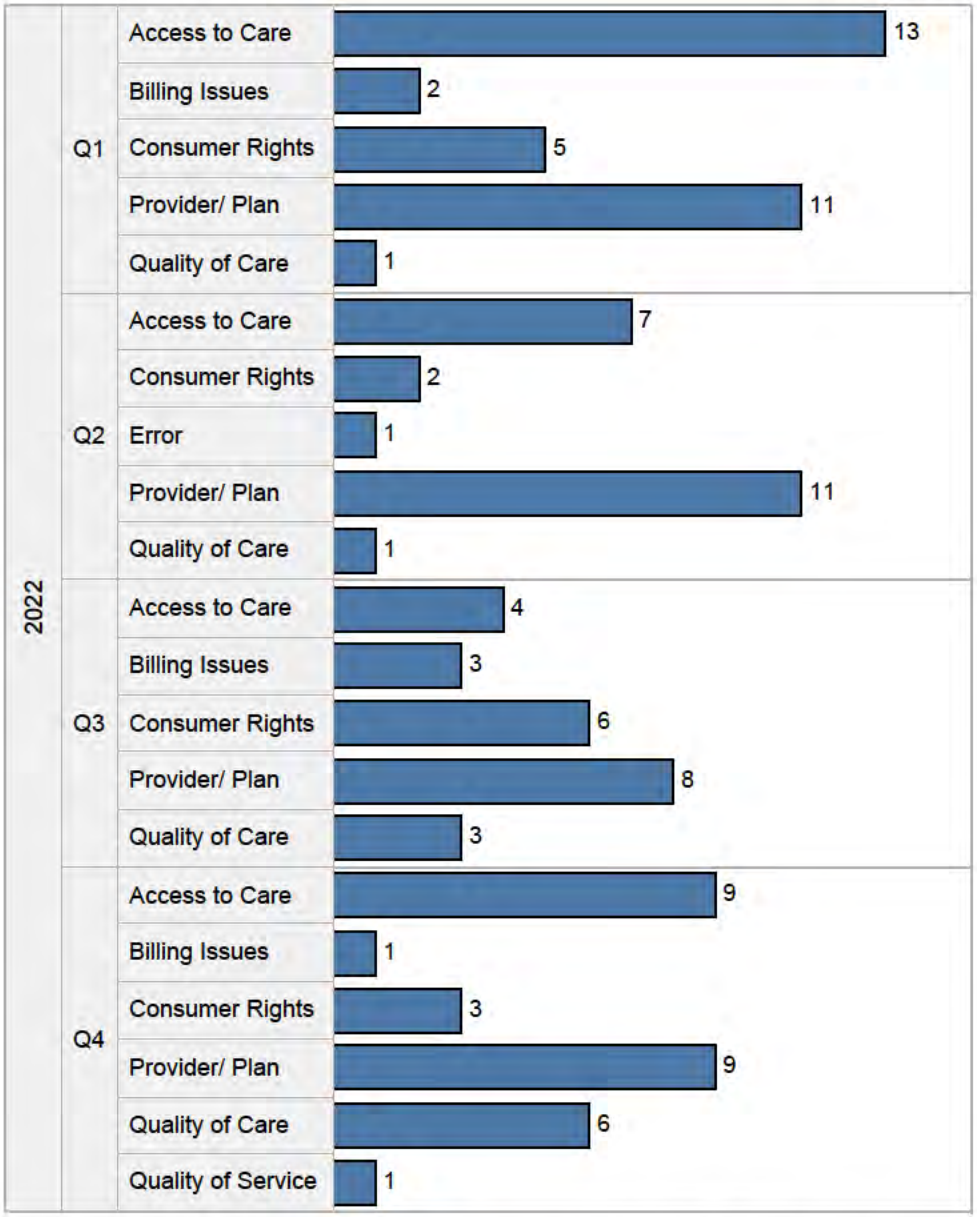
GRIEVANCES YEAR OVER YEAR

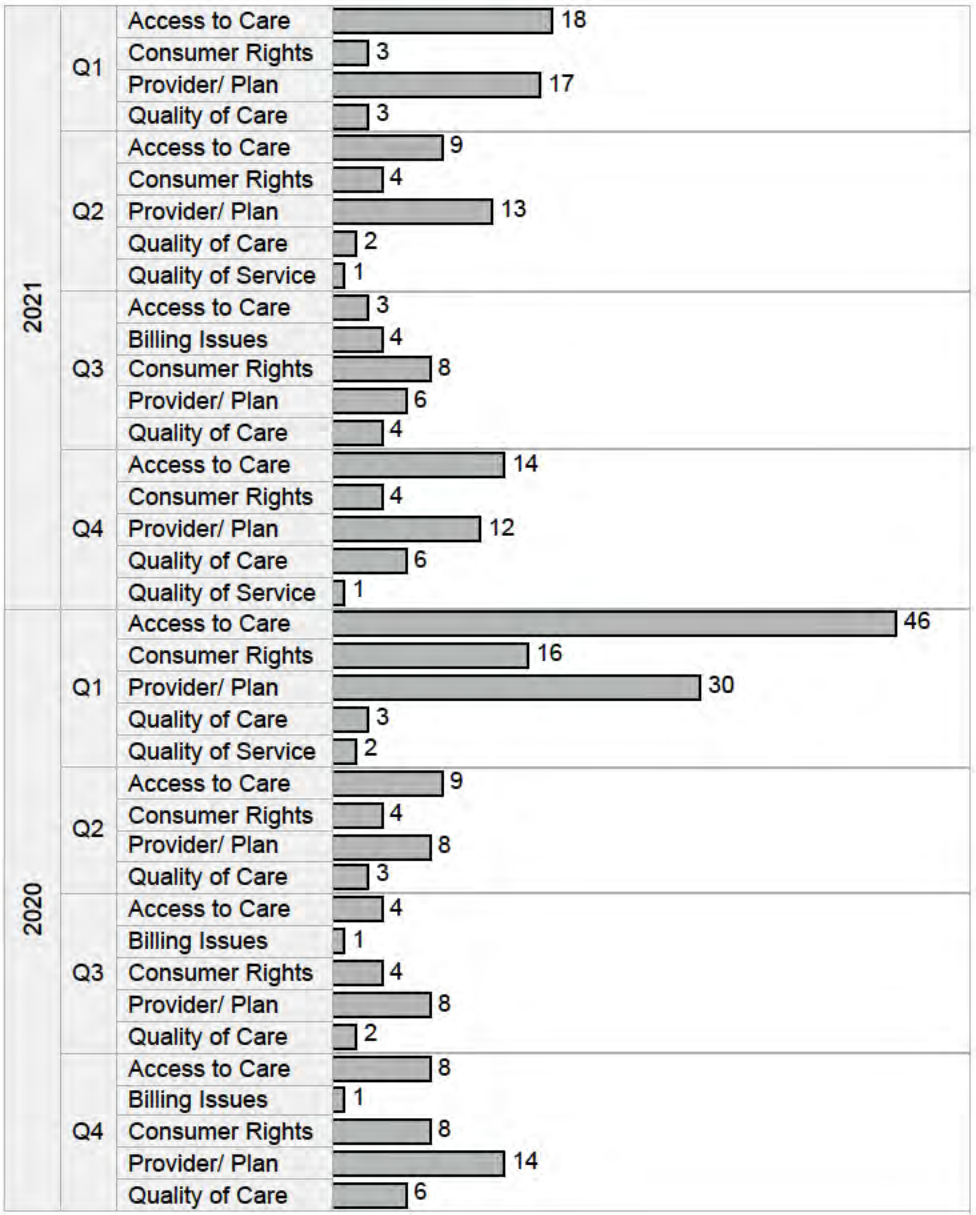
Cascade Health Alliance

2/7/2023
Danielle Sherman

Service Type All

Grievances by Cateogry





Grievance Activity: 1/1/2020 - 12/31/2022 Extracted: 2/7/2023 **Source:** and Compliance

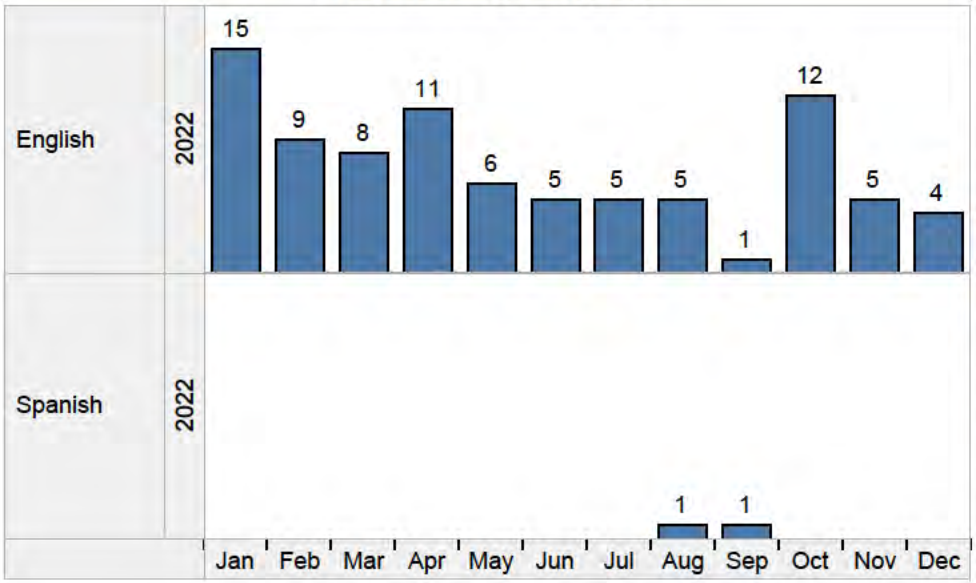
GRIEVANCES YEAR OVER YEAR

Cascade Health Alliance

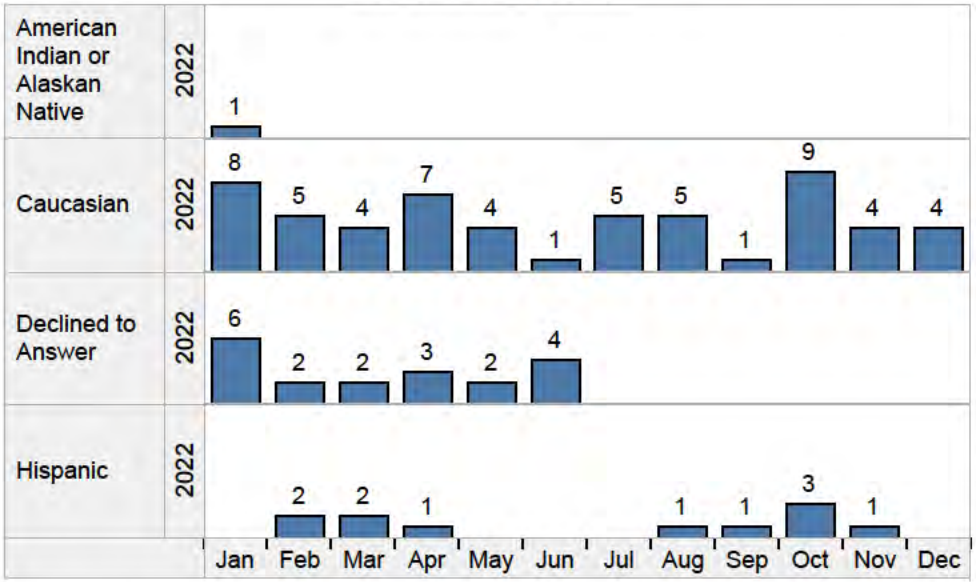
2/7/2023
Danielle Sherman

Service Type All

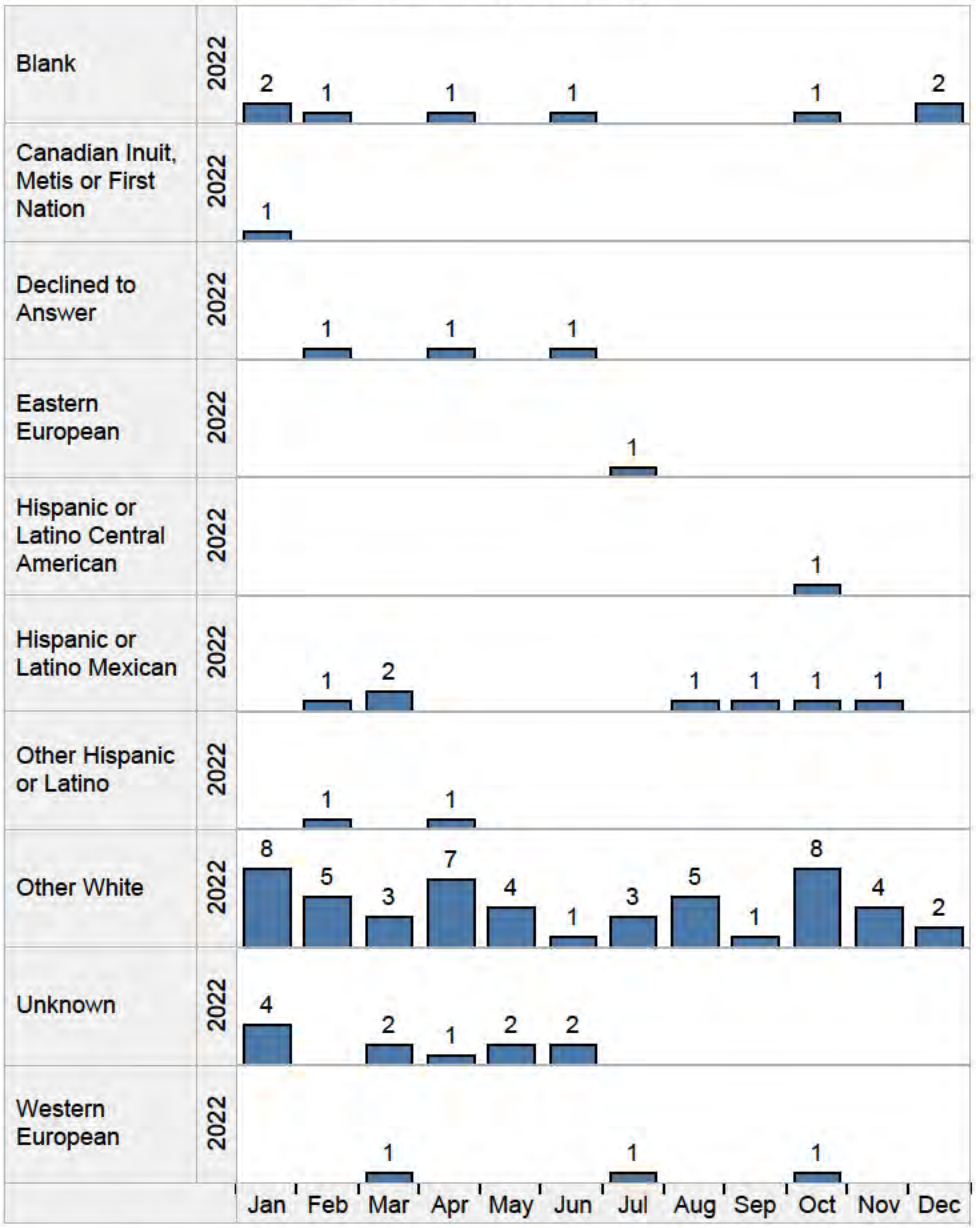
Grievances by Language



Grievances by Race



Grievances by Ethnicity



Grievance Activity: 1/1/2020 - 12/31/2022 Extracted: 2/7/2023 **Source:** and Compliance *Members current/most recent REAL data.

GRIEVANCES YEAR OVER YEAR

Cascade Health Alliance

2/7/2023
Danielle Sherman

Count of 2021 Grievances - Service Type 9 (Oral Health)

	ADVANTAGE DENTAL		CHASE FAMILY DENTISTRY	KLAMATH DENTAL CENTER	KLAMATH HEALTH PARTNERSHIP PCD		KLAMATH SMILES	OREGON INSTITUTE OF TECHNOLOGY			SHASTA FAMILY DENTAL	TIMBER KIDS DENTISTRY			WASHBURN SMILES		WESTERN DENTURE	Grand Total
	2021	2022	2020	2020	2020	2021	2021	2020	2021	2022	2020	2020	2021	2022	2020	2021	2020	
A.a) Provider's office unresponsive, not available, difficult to contact for appt or info				1	2			2	2			10			5			22
A.c) Provider's office too far away, not convenient															2			2
A.d) Unable to schedule appointment in a timely manner					5					1	4	1	2		4			17
A.e) Unable to be seen in a timely manner for urgent/emergent care					1	1					1		4	1	2	1		11
A.i) Provider not available to give necessary care	1	1				1					1		9	8	3	9		33
CR.b) Concern over confidentiality														1				1
CR.c) Member dissatisfaction with treatment plan (not involved)			1		4						1	2		1	6	1		16
IP.a) Wants to change providers; provider not a good fit		2			1					1	2				6			12
IP.b) Provider rude or inappropriate comments or behavior			1	2					1						4		1	9
IP.d) Provider explanation/instruction inadequate/incomplete													1		1			2
IP.e) Plan explanation/instruction inadequate/incomplete															1			1
IP.f) Wait too long in office before receiving care	1												1		6			8
IP.g) Member not treated with respect and due consideration for dignity and privacy												1			1			2
IP.k) Lack of communication and coordination among providers						1							1					2
IP.m) Dismissed by clinic (member misbehavior, miss appts, etc.)			1				1											2
QC.a) Received appropriate care, but experienced an adverse outcome				1	3				1						2	1		8
Total	**2**	**3**	**3**	**4**	**16**	**3**	**1**	**2**	**4**	**2**	**9**	**14**	**18**	**11**	**43**	**12**	**1**	**148**

1 — 10

Grievance Activity: 1/1/2020 - 12/31/2022 Extracted: 2/7/2023 **Source:** and Compliance

GRIEVANCES YEAR OVER YEAR

Cascade Health Alliance

2/7/2023
Danielle Sherman

Count of 2021 Grievances - Service Type 15 (PCP)

	CASCADES EAST FAMILY PRACTICE			KLAMATH HEALTH PARTNERSHIP PCP			MICHAEL SHEETS	SANFORD CHILDRENS CLINIC			SKY LAKES PRIMARY CARE			THE CHILDRENS CLINIC		THE MERRILL CLINIC	Grand Total
	2020	2021	2022	2020	2021	2022	2021	2020	2021	2022	2020	2021	2022	2020	2021	2020	
A.a) Provider's office unresponsive, not available, difficult to contact for appt or info			1		1			1									3
A.c) Provider's office too far away, not convenient										1							1
A.d) Unable to schedule appointment in a timely manner		1		4				3									8
A.e) Unable to be seen in a timely manner for urgent/emergent care				3													3
A.i) Provider not available to give necessary care				1				1	1								3
CB.c) Billing OHP clients without a waiver		1															1
CR.c) Member dissatisfaction with treatment plan (not involved)	4	3			2				2		2	1			1	1	16
CR.d) No choice of clinical or clinician choice not available	1					1											2
IP.a) Wants to change providers; provider not a good fit		2		2	2	1		2			2			2	1		14
IP.b) Provider rude or inappropriate comments or behavior	2	2		5	2		1	1	1		1				1		16
IP.c) Plan rude or inappropriate comments or behavior									2								2
IP.d) Provider explanation/instruction inadequate/incomplete									2		1			1			4
IP.l) Dismissed by provider (misbehaoior, missed appts, etc)						1											1
IP.m) Dismissed by clinic (member misbehavior, miss appts, etc.)		1			1								1				3
QC.a) Received appropriate care, but experienced an adverse outcome									1		1						2
QC.c) Concern about prescriber or medication or medication management is..	1	1															2
QC.d) Member neglect or physical, mental or psychological abuse					1												1
Total	**8**	**11**	**1**	**15**	**9**	**3**	**1**	**8**	**9**	**1**	**7**	**1**	**1**	**3**	**3**	**1**	**82**

1 — 5

Grievance Activity: 1/1/2020 - 12/31/2022 Extracted: 2/7/2023 **Source:** and Compliance

GRIEVANCES YEAR OVER YEAR

Cascade Health Alliance

2/7/2023
Danielle Sherman

Count of 2021 Grievances - Excluding Service Type 9 (Oral Health) and 15 (PCP)

	CARTER JONES COLLECTIONS	CREDIT BUREAU OF KLAMATH	DURABLE MEDICAL EQUIPMENT	GENETIC TESTING	INDIVIDUAL & FAMILY GROWTH CENTER	KLAMATH BASIN BEHAVOIRAL HEALTH			KLAMATH EYE CENTER		KLAMATH ORTHOPEDIC			KLAMATH PULMONARY	Grand Total
	2021	2021	2020	2020	2020	2020	2021	2022	2020	2021	2020	2021	2022	2021	
A.a) Provider's office unresponsive, not available, difficult to contact for appt or info							2								2
A.d) Unable to schedule appointment in a timely manner											1				1
CB.a) Co-pays										1					1
CB.c) Billing OHP clients without a waiver	1	1		1											3
CR.b) Concern over confidentiality						1	1								2
CR.c) Member dissatisfaction with treatment plan (not involved)						2	1	1					1	1	6
CR.f) Provider bias barrier							2								2
IP.a) Wants to change providers; provider not a good fit						1	1								2
IP.b) Provider rude or inappropriate comments or behavior					1	3	8	4							16
IP.d) Provider explanation/instruction inadequate/incomplete								1							1
IP.g) Member not treated with respect and due consideration for dignity and privacy							1								1
IP.k) Lack of communication and coordination among providers							2		1						3
IP.l) Dismissed by provider (misbehaoior, missed appts, etc)							1								1
QC.a) Received appropriate care, but experienced an adverse outcome								1				1			2
QC.b) Testing/assessment insufficient, inadequate or omitted							1								1
QC.c) Concern about prescr ber or medication or medication management issu..						2		1							3
QC.f) Lack of appropriate individualized setting in treatment							1								1
QS.a) Delay in receiving or concern regarding quality of materials/supplies (DM..			1												1
Total	**1**	**1**	**1**	**1**	**1**	**9**	**21**	**8**	**1**	**1**	**1**	**1**	**1**	**1**	**49**

1 — 8

Grievance Activity: 1/1/2020 - 12/31/2022 Extracted: 2/7/2023 **Source:** and Compliance

GRIEVANCES YEAR OVER YEAR

Cascade Health Alliance

2/7/2023
Danielle Sherman

Count of 2021 Grievances - Excluding Service Type 9 (Oral Health) and 15 (PCP)

	NEMT			PLAN/PROGRAM		QUAVE CLINIC	SKY LAKES DERMATOLOGY	SKY LAKES EMERGENCY DEPT		SKY LAKES MEDICAL CENTER	SKY LAKES OUTPATIENT IMAGING	SKY LAKES PRIMARY CARE	SKY LAKES RHEUMATOLOGY		VERACYTE	Grand Total
	2020	2021	2022	2020	2021	2021	2020	2020	2021	2021	2020	2020	2020	2021	2020	
A.i) Provider not available to give necessary care		1														1
A.l) NEMT not provided, late pick up with missed appointment, no coordination of services	9	8	3													20
CB.c) Billing OHP clients without a waiver															1	1
CR.c) Member dissatisfaction with treatment plan (not involved)				4		1		1		1		1				8
CR.d) No choice of clinical or clinician choice not available					1								1			2
IP.a) Wants to change providers; provider not a good fit	1															1
IP.b) Provider rude or inappropriate comments or behavior							1		1	1				1		4
IP.c) Plan rude or inappropriate comments or behavior					2											2
IP.e) Plan explanation/instruction inadequate/incomplete	2	2	1	2	1											8
IP.k) Lack of communication and coordination among providers	1															1
QC.a) Received appropriate care, but experienced an adverse outcome	1	1									1					3
QC.c) Concern about prescr ber or medication or medication management issues				1	2											3
QC.e) Provider office unsafe/unsanitary environment or equipment	1															1
QS.a) Delay in receiving or concern regarding quality of materials/supplies (DME) or dental				1												1
QS.c) Benefits not covered					1											1
Total	**15**	**12**	**4**	**8**	**7**	**1**	**1**	**1**	**1**	**2**	**1**	**1**	**1**	**1**	**1**	**57**

1 9

Grievance Activity: 1/1/2020 - 12/31/2022 Extracted: 2/7/2023 **Source:** and Compliance

GRIEVANCES YEAR OVER YEAR

"A" = Access to Care

A.a) Provider's office unresponsive, not available, difficult to contact for appt or info
A.b) Plan unresponsive, not available, difficult to contact for appointment or information.
A.c) Provider's office too far away, not convenient
A.d) Unable to schedule appointment in a timely manner.
A.e) Unable to be seen in a timely manner for urgent/emergent care
A.f) Provider's office closed to new patients.
A.g) Referral or 2nd opinion denied/refused by provider.
A.h) Referral or 2nd opinion denied/refused by plan.
A.i) Provider not available to give necessary care
A.j) Eligibility issues
A.k) Female or male provider preferred, but not available
A.l) NEMT not provided, late pick up w/missed appointment, no coordination of services
A.m) Dismissed by provider as a result of past due billing issues
A.n) Dismissed by clinic as a result of past due billing issues
A.o) Verbal denial of service by Provider
A.p) Verbal denial of service by Plan

"CR" = Consumer Rights

CR.a) Provider's office has a physical barrier/not ADA compliant, prevents access to office, lavatory, examination room, etc.
CR.b) Concern over confidentiality.
CR.c) Member dissatisfaction with treatment plan (not involved, didn't understand, choices not reflected, not person centered, disagrees, tooth not restorable, preference for individual settings vs. group, treatment options not discussed)
CR.d) No choice of clinical or clinician choice not available
CR.e) Fraud and financial abuse
CR.f) Provider/Plan bias barrier (age, race, religion, sexual orientation, mental/physical health, marital status, Medicare/Medicaid)
CR.g) Complaint/appeal process not explained, lack of adequate or understandable NOA
CR.h) Not informed of consumer (Member) rights
CR.i) Member denied access to medical records (other than as restricted by law)
CR.j) Did not respond to members request to amend inaccurate or incomplete information in the medical record (includes right to submit a statement of disagreement)
CR.k) Advanced or Mental Health Directive not discussed, offered or followed.
CR.l) Concern that a form of restraint or seclusion was used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion. Restraint or seclusion used other than to assure members immediate safety.

"CB" = Client Billing Issues

CB.a) Co-pays
CB.c) Member complaint about OHP clients receiving a bill, without signing a waiver

"IP" = Interaction with Provider or Plan

IP.a) Wants to change providers; provider not a good fit
IP.b) Provider rude or inappropriate comments or behavior
IP.c) Plan rude or inappropriate comments or behavior
IP.d) Provider explanation/instruction inadequate/incomplete
IP.e) Plan explanation/instruction inadequate/incomplete
IP.f) Wait too long in office before receiving care
IP.g) Member not treated with respect and due consideration for his/her dignity and privacy
IP.h) Provider's office or/and provider exhibits language or cultural barriers or lack of cultural sensitivity, interpreter services not available.
IP.i) Plan's office or staff exhibits language or cultural barriers or lack of cultural sensitivity
IP.j) Member has difficulty understanding provider due to language or cultural barriers.
IP.k) Lack of communication and coordination among providers
IP.l) Dismissed by provider (member misbehavior, missed appts. etc.)
IP.m) Dismissed by clinic (member misbehavior, missed appts. Etc.)

"QC" = Quality of Care

QC.a) Received care, experienced an adverse outcome, complications, misdiagnosis or concern related to provider care.
QC.b) Testing / assessment insufficient, inadequate or omitted
QC.c) Concern about prescriber or medication or medication management issues (prescribed non-formulary medication, unable to get prescription filled or therapeutic alternative recommended by Provider or Plan)
QC.d) Member neglect or physical, mental or psychological abuse
QC.e) Provider office unsafe/unsanitary environment or equipment
QC.f) Lack of appropriate individualized setting in treatment.

"QS" = Quality of Service

QS.a) Delay in receiving or concern regarding quality of materials and supplies (DME) or dental
QS.c) Benefits not covered

YEAR OVER YEAR APPEALS (NOAR)

Cascade Health Alliance

2/9/2023
Danielle Sherman

Service Type All

Appeals by Month

Appeals by Service Type

	2020	2021	2022
1) DME	5%	10%	5%
2) OT		1%	1%
3) PT	2%		2%
4) Hospital	1%		
8) Pharmacy	12%	11%	10%
9) Dental	19%	9%	16%
10) MH		1%	
11) Pain Mgt	3%	3%	
13) Specialty	45%	49%	44%
19) Imaging	6%	5%	13%
20) NEMT	2%	2%	1%
21) Vision	4%	8%	4%
23) Chiropractic	1%	3%	1%
24) Acupuncture	1%		2%

Average Determination (Days)

2020				2021				2022			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
5.76	4.36	5.67	3.16	3.61	4.86	4.79	5.71	3.73	4.76	4.72	5.00

Appeal Requests: 01/01/2020 - 12/31/2022 **Updated:** 2/7/2023 **Source:** MedImpact and Sky Lakes

OHA Project #61

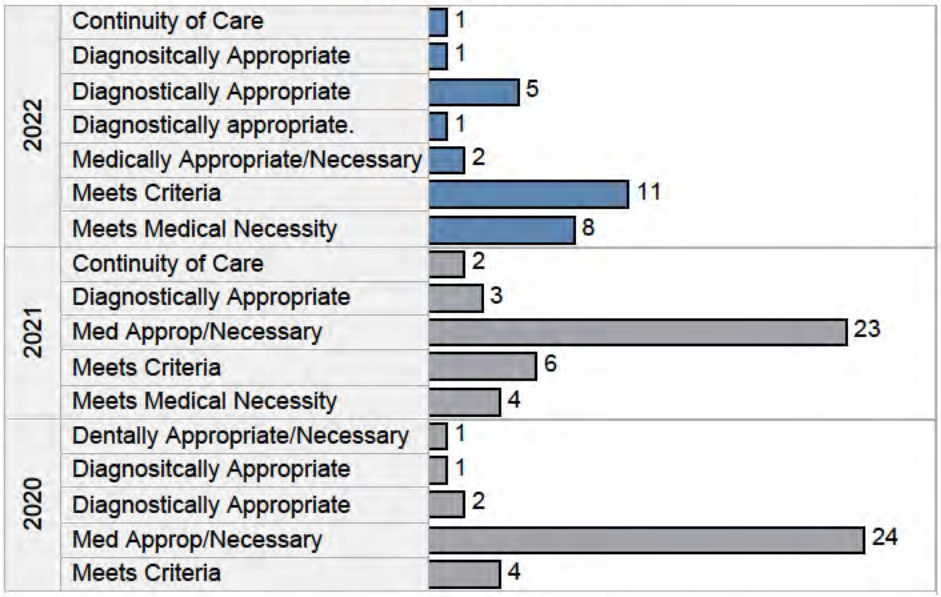
YEAR OVER YEAR APPEALS (NOAR)

Cascade Health Alliance

2/9/2023
Danielle Sherman

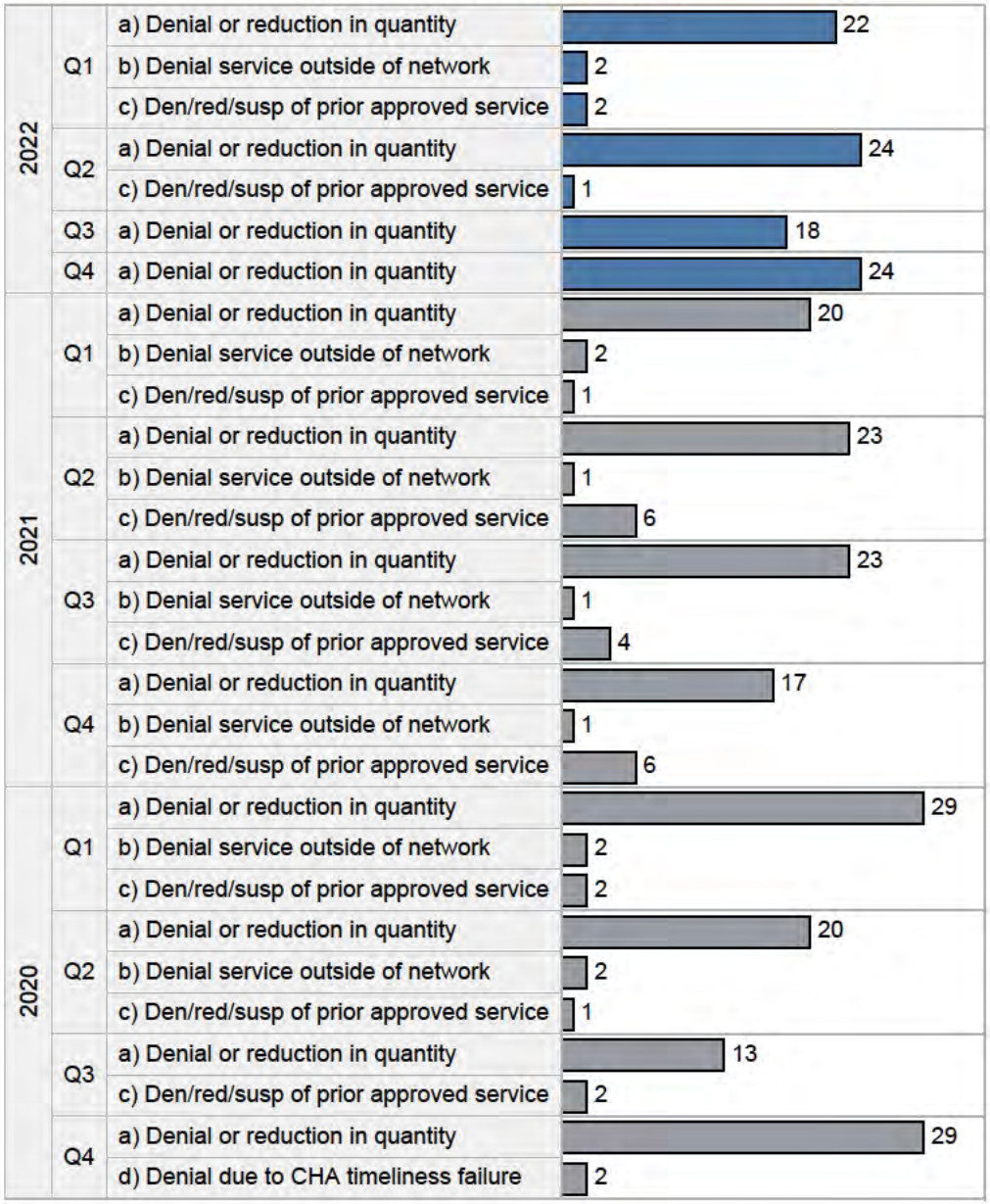
Service Type All

Overturned Appeals



		Overturned	Total	Percent Overturned
2022	Q1	9	26	34.6%
	Q2	9	25	36.0%
	Q3	5	18	27.8%
	Q4	6	24	25.0%
2021	Q1	6	23	26.1%
	Q2	15	30	50.0%
	Q3	7	28	25.0%
	Q4	10	24	41.7%
2020	Q1	9	33	27.3%
	Q2	7	23	30.4%
	Q3	4	15	26.7%
	Q4	12	31	38.7%

Appeals by Action Category



Appeal Requests: 01/01/2020 - 12/31/2022 **Updated:** 2/7/2023 **Source:** MedImpact and Sky Lakes

OHA Project #61

YEAR OVER YEAR APPEALS (NOAR)

Cascade Health Alliance

2/9/2023
Danielle Sherman

Action Category

a) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. 42 CFR §438.400(b)(1)
Explanation: A member or member's doctor requests a servcie and the MCE determines the member:
- Cannot have the service;
- Can have the service, but not the number or in the service requested (ex. A member requests 10 PT visits, but is only granted 5 PT visits or, a member requests 3 month supply of medication, but they are only granted 1 month supply);
- The service requested is for a setting that the MCE believes is not appropriate (ex. A member requests to have a dental procedure in a hospital, bu the MCE dcides the member does not meet MCE criteria for a hopsiatl dental procedure);
- Requested a service that is determined by the MCE to be experimental, investigative, or not medicall necessary;
- Was/is not eligiblt for OHP at the time services were/are requested;
- Requested a service that is not a covered service; or
- Record is missing information necessary for the MCE to approve the requested service.

b) Denial of a member's request to obtain services outside the managed care entity panel. Use this category when the MCE is denying a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network (42 CFR 438.400(b)(6).
Explanation: When an MCE does not agree (approve) to let a member access services outside of the MCE provider network, this is an adverse benefit determination.

c) The reduction, suspension, or termination of a previously authorized service. 42 CFR §438.400(b)(2)
Explanation: When the MCE stops or decreases a service a member is already receiving, this is an ABD.

d) The failure of an MCE to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. 42 CFR §438.400(b)(5)
Explanation: When the MCE stops or decreases a service a member is already receiving, this is an ABD.

e) The failure to provide services in a timely manner, as defined by the State. 42 CFR §438.400(b)(4)
Explanation: When a member has to wait longer than standard, urgent or emergency timeframes in the MCE Contract and OAR to get health care or receive a service, this is an ABD and the MCE must send the member an NOABD.

f) The denial, in whole or in part, of payment for a service. 42 CFR §438.400(b)(3)
Explanation: a member has already received a service, but the MCE determines that it cannot pay for the service; this is an adverse benefit determination.

g) Denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. Use this category for ABD issued by the MCE to deny a member's request to dispute a financial liability (42 CFR 438.400(b)(7).
Explanation: A member received a bill for services that they believe the MCE should have paid for, but didn't. If the MCE investigates and determines that the member signed an 'agreement to pay form' and the member is required to pay, the MCE must send the member a NOABD.

Sub Category Catories a, c, and f must have a sub category

1) Treatment is not a covered service
2) Requires PA and was not preauthorized (includes non-panel provider requirement for PA)
3) The service is not medically appropriate
4) The service or item was received in an emergency care setting and does not qualify as an emergency service.
5) The Provider is not on the Contractor's panel and prior approval was not obtained (if such prior authorization would be required under OHP rules)

2020/2021 DENIALS (NOABD)

Cascade Health Alliance

2/13/2023
Danielle Sherman

Denials by Month

Denials by Service Type

	2020	2021	2022
1) DME	4%	6%	7%
2) OT		0%	0%
3) PT	2%	1%	1%
4) Hospital	0%		
8) Pharmacy	52%	45%	38%
9) Dental	5%	5%	5%
10) MH	0%	1%	1%
11) Pain Mgt	1%	0%	1%
12) SUD	0%	0%	0%
13) Specialty	17%	19%	22%
16) Outpatient	1%	1%	1%
17) Other	2%	3%	2%
18 Diagnostic	1%	1%	2%
19) Imaging	4%	6%	7%
20) NEMT	5%	5%	6%
21) Vision	3%	4%	4%
23) Chiropractic	2%	3%	2%
24) Acupuncture	1%	1%	1%

Average Determination (Days)

2020				2021				2022			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
3.21	2.67	5.73	3.06	3.13	5.61	6.35	7.38	6.11	4.14	6.96	6.45

Denial Activity: 1/1/2020 - 12/31/2022 **Updated:** 2/13/2023 **Source:** and Sky Lakes

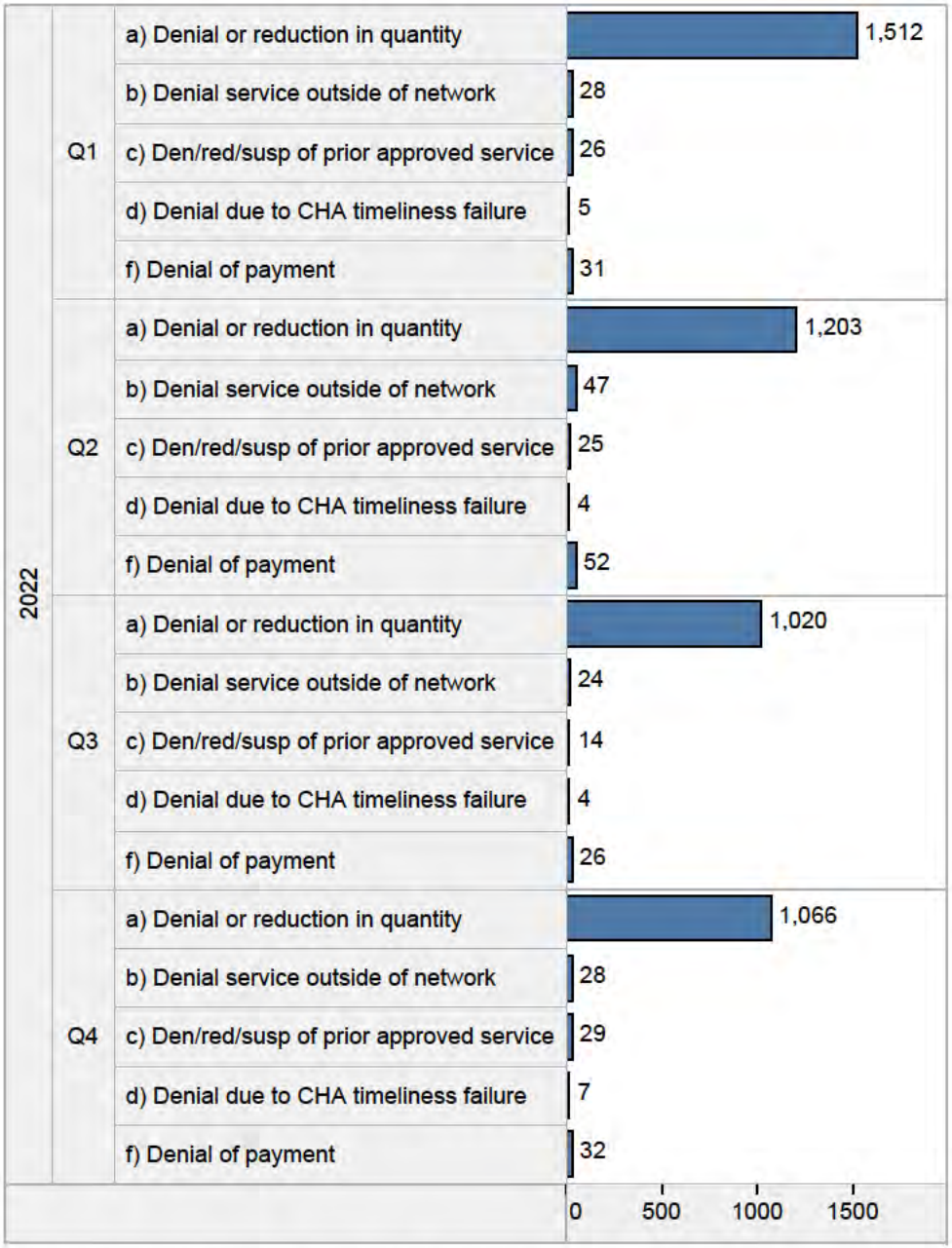
OHA Project #61

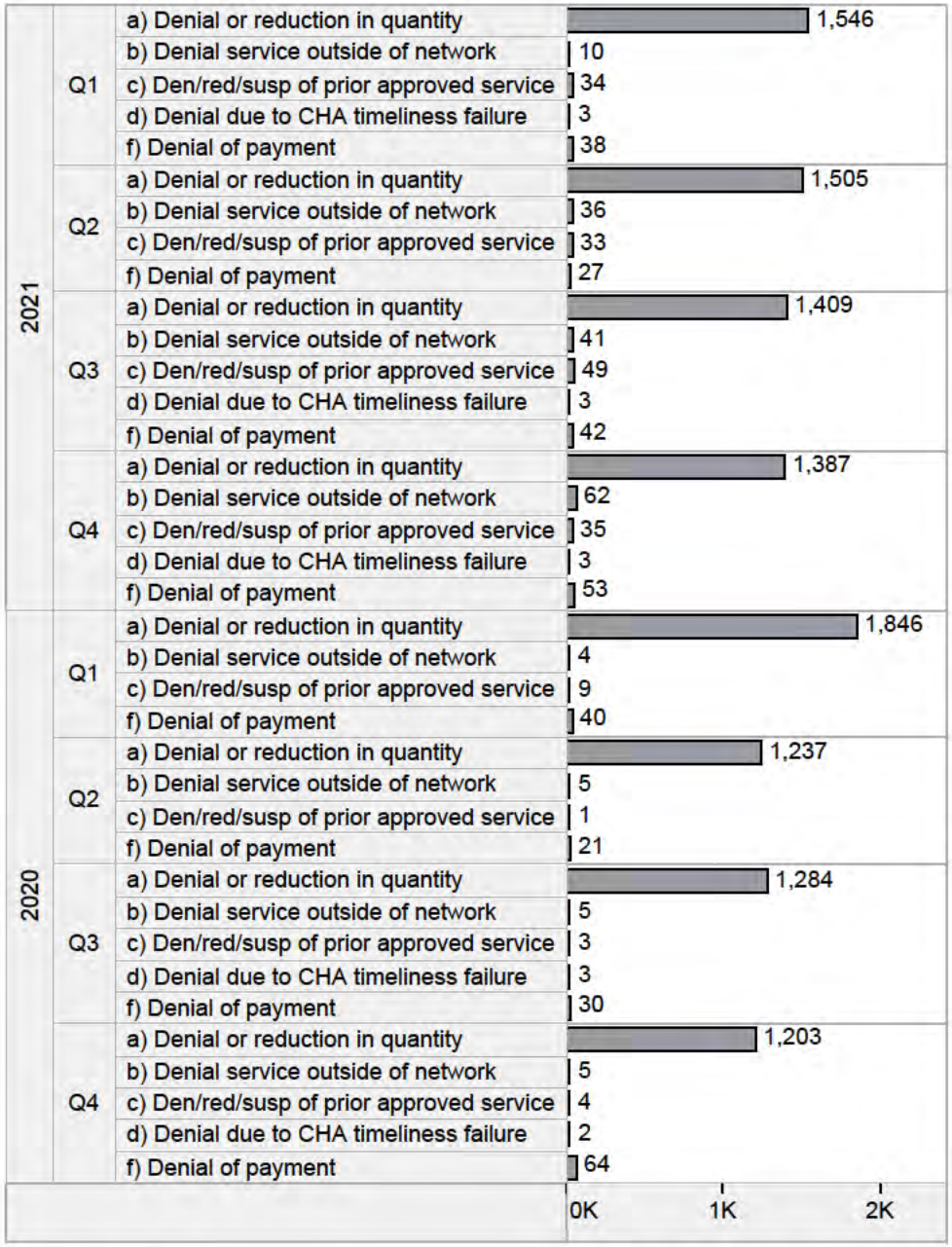
2020/2021 DENIALS (NOABD)

Cascade Health Alliance

2/13/2023
Danielle Sherman

Denials by Action Category





Denial Activity: 1/1/2020 - 12/31/2022 **Updated:** 2/13/2023 **Source:** and Sky Lakes

ACTIVE MEMBER DEMOGRAPHICS

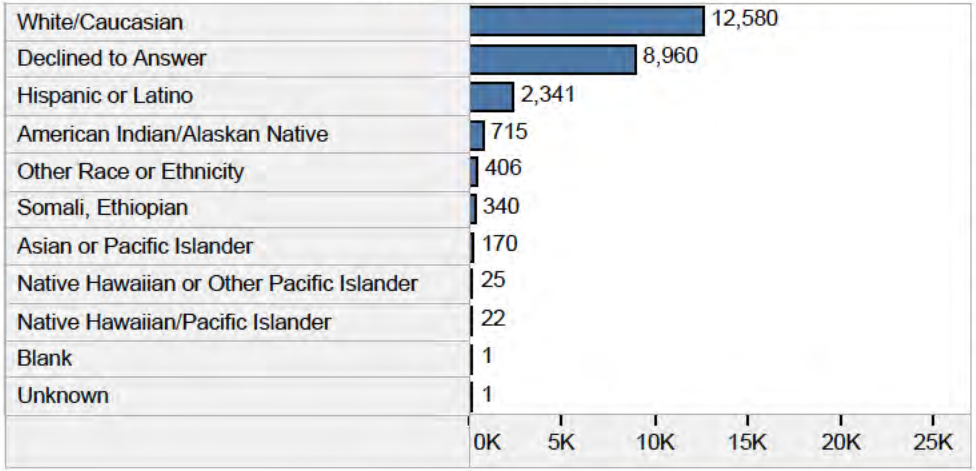
Cascade Health Alliance

12/14/2022

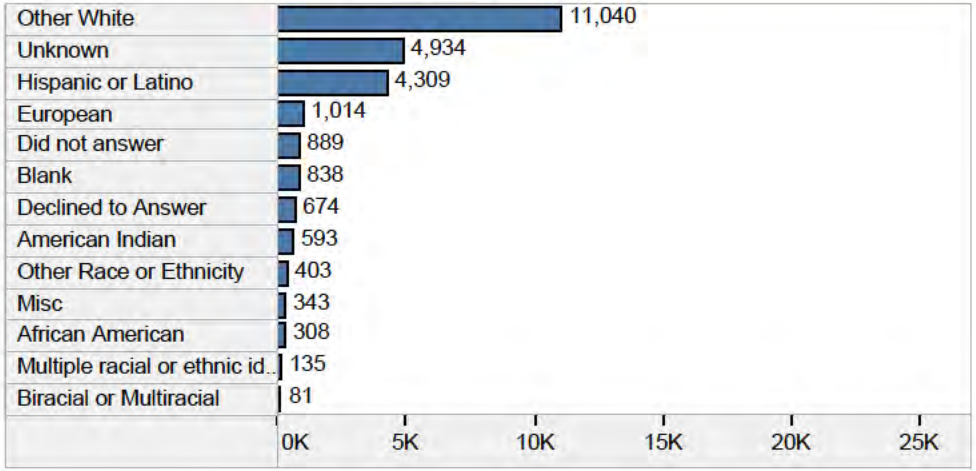
Race	All	**Ethnicity**	All	**Language**	All
City	All	**Age**	All	**Health Plan**	All

Total Members	Total Males	Total Females	Members with Disability	Dual Eligible Members
25,560	12,324	13,236	2,245	2,166

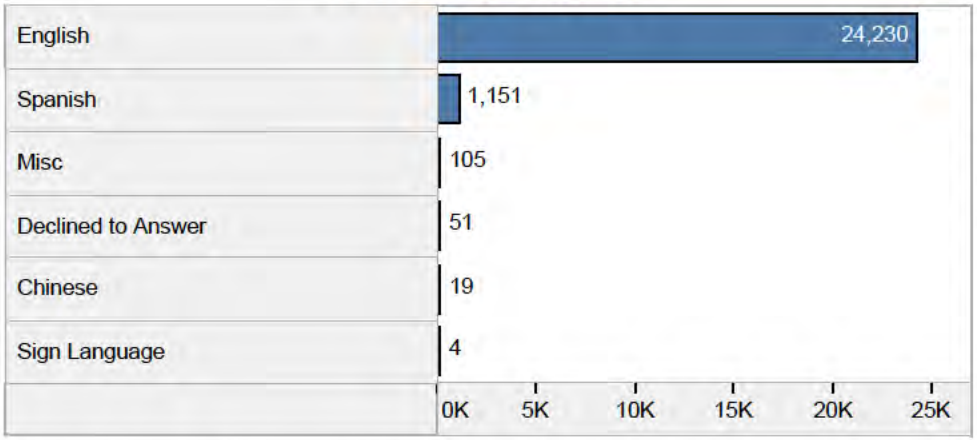
Members by Race



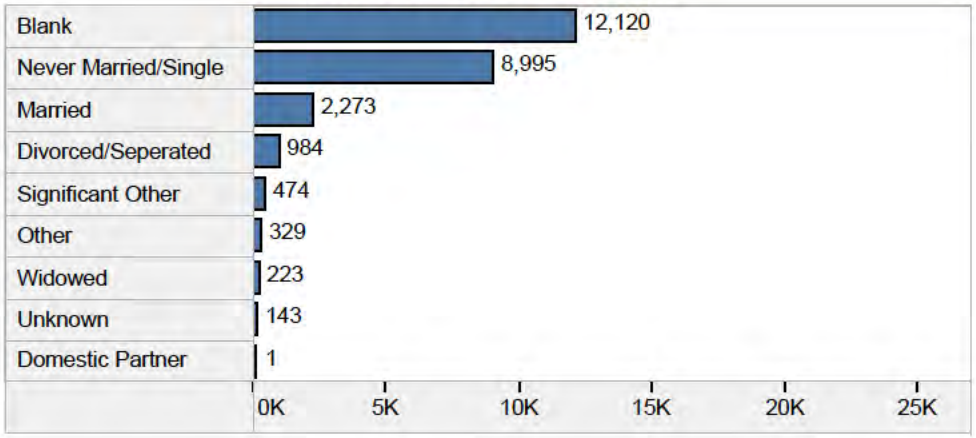
Members by Ethnicity



Members by Language



Members by Marital Status



Membership: Active Members on 11/30/2022 **Updated:** 12/14/2022 **Source:** and Reliance

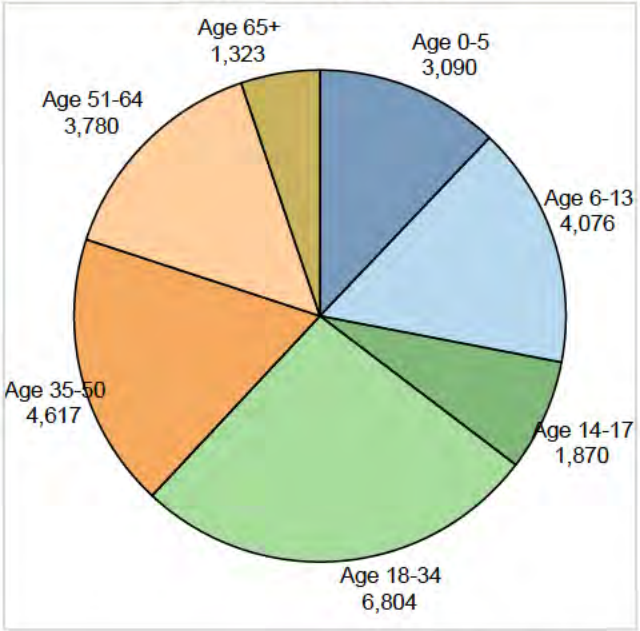
OHA Projects #61, #33

ACTIVE MEMBER DEMOGRAPHICS

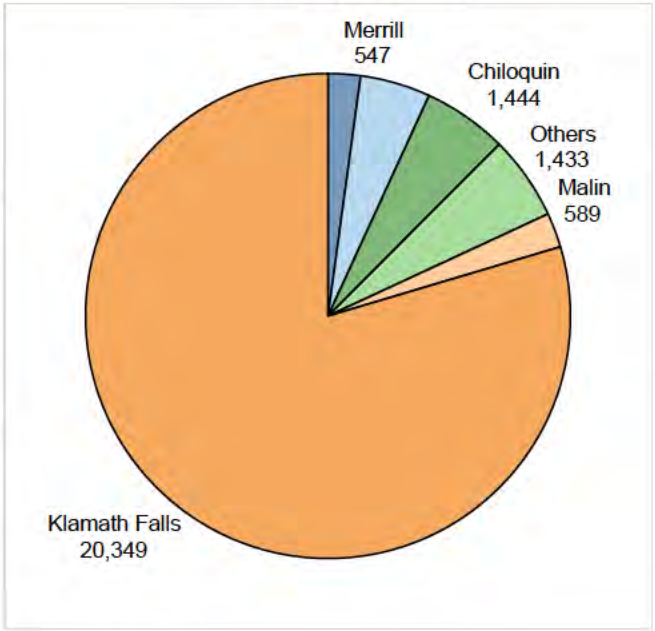
Cascade Health Alliance

12/14/2022

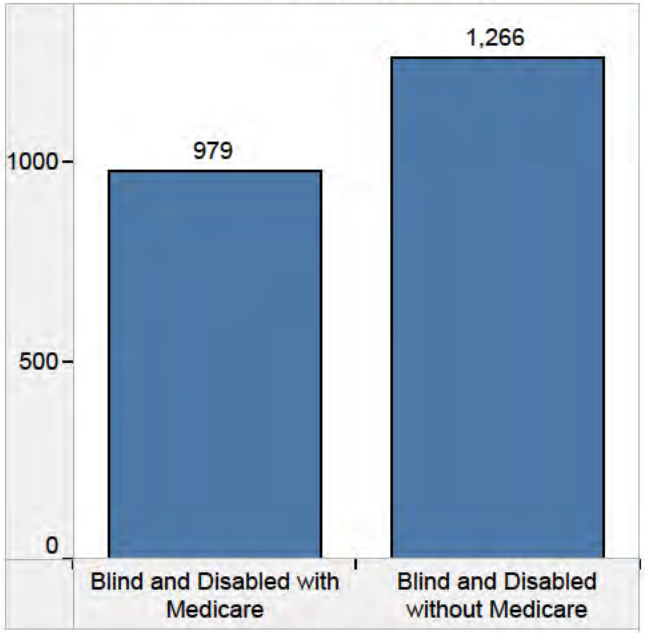
Members by Age Bin



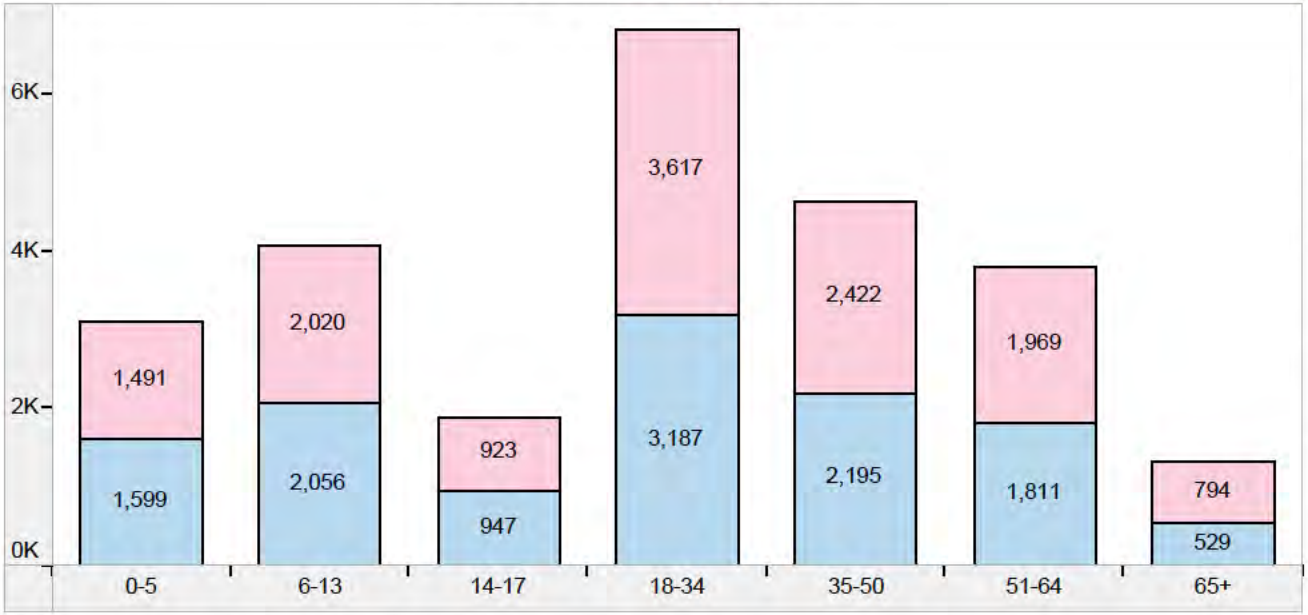
Members by Location



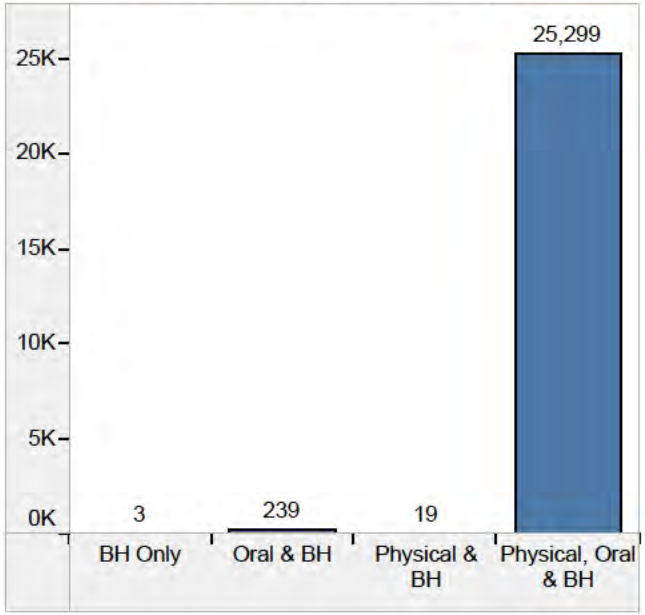
Members with Disability



Member Gender by Age Bin



Members by Benefit Plan



Membership: Active Members on 11/30/2022 **Updated:** 12/14/2022 **Source:** and Reliance

OHA Projects #61, #33

Provider Training

OHA Project #61

Grievances, Appeals, Hearings, and Reconsiderations

Cascade Hea

Grievances and Appeals

- Appeals of denied services can be filed by members within 60 days of denial notice (NOABD), may be filed in writing or Verbally – new OHA requirement
- Expedited appeals & continuation of benefits (COB) may be requested
- COB requests must be made within 10 days of denial
- Appeal determinations made— 16 days
- Expedited & COB determinations— 72 hours
- CHA assists members in filing appeals upon request
- Grievances of any issue other than a denial can be filed by members anytime, verbally or in writing
- Grievance resolutions— 30 days (maximum)

Contested Case Hearings

- Members may request hearings if they **disagree** with the appeal determination
- OHA **requires** an appeal of the denied service be completed before hearing request
- Hearings normally requested within 120 days from the "Date of Notice" on the Notice of Appeal Resolution (NOAR)
  - Due to COVID-19, OHA is allowing an additional 120 days for these requests, total of 240 days from date of NOAR – Timeframe still valid
- Hearings are **arranged by OHA** and occur 30 – 45 days from request
- Hearings are conducted by phone & determinations are made by the Administrative Law Judge (ALJ) with the Office of Administrative Hearings (OAH)
- Decisions are **not made** at the hearing but **are mailed** to members within 30 **days of hearing**

Provider Reconsiderations

- Provider **reconsideration** of denied services must be filed within 30 days of denial
- **Written** requests must include **letter** and **any supporting documentation (**chart notes/notes on auth summary alone is insufficient**)** and can be **faxed** to CHA
  - Fax ATTN: Recons at (541) 882-6914
- **Oral** requests can be requested **via Peer-to-Peer Reconsideration** conversation with Medical Director
  - Scheduling Required through CHA Appeals & Grievances at (541) 851-2078
- Requests must be made by **provider with permission to act on member's behalf**
- Reconsideration determinations – 30 Days
- Determination letters sent to **requesting provider** with **approved authorization** when **applicable**

Provider Dismissal of Member

- PCP/PCDs may terminate member care with due cause as outlined in provider's policy
  - Examples: three or more "no show" appointments in 12 months, member abuse of provider or staff, member threats to provider or staff
    - Notify CHA immediately of credible threats of violence from member
- Providers considering terminating a member from care should contact CHA Compliance for alternatives to termination.
  - ***CHA may be able to provide you with Resources and/or can contact member for possible solution***
- Dismissals must be initiated by provider, mailed to member, and copied to CHA via USPS mail, fax or email
  - Fax ATTN: compliance/dismissals at (541) 882-6914
  - Email: compliance@cascadecomp.com

Provider Dismissal of Member (continued)

- Dismissal letters must reference reason for termination and effective date
- Dismissal letters must direct member to contact CHA to be reassigned to another provider
- Dismissals must relate member will be seen by provider for 30 days from date of letter to allow for emergent care
- Members terminated from care can request clinical documentation be transferred to new provider
- ***CHA will not terminate member from care but will reassign member upon receipt of dismissal***
- Questions regarding dismissal/termination of care can be addressed to compliance@cascadecomp.com

Example Provider Dismissal of Member Letter

DATE

ADDRESS
ADDRESS
ADDRESS

MEMBER ID#

Dear Member,

Effective DATE, CLINIC NAME will be unable to serve as your (Primary Care Provider/Primary Care Dentist/Dental Care Provider) under your Oregon Health Plan. (ENTER REASON IF APPLICABLE). We ask that you call Cascade Health Alliance Member Services at 541-883-2947 to be assigned to a new (Primary Care Dentist/Dental Care Provider).

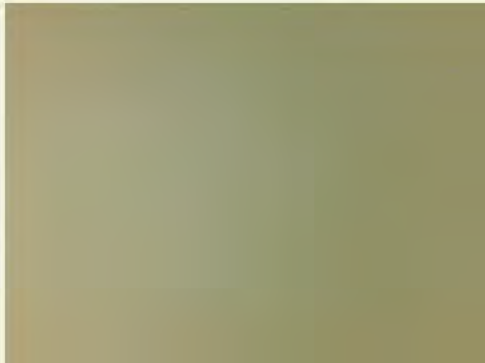
Our office will continue to be available to you for emergency care for a period of up to 30 days while you are seeking other (Primary Care/Primary Dental Care) services.

If you wish to have copies of your care records and x-rays, please contact our office CONTACT INFO to let us know the new (Primary Care Provider/Primary Dental Care Provider) that will be providing your care.

If you have any questions about this letter, please call CHA Member Services at 541-883-2947.

Sincerely,

NAME/CLINIC/Manager



Cascade Health Alliance, LLC

cascade comprehensive care, inc.

PROVIDER DISMISSAL OF MEMBER POLICY AND PROCEDURE

In this document, CCC is referenced in place of CCC and CHA.

CONTENTS

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Terms not defined in the DEFINITIONS section of this document may be found in the Glossary.

CCC is committed to ensuring all members are provided culturally competent care and services. We provide equal opportunity to members to obtain healthcare that recognizes their experiences, cultural diversity and needs, preferred language, and is inclusive of all protected classes: race, ethnicity, color, National origin, citizenship, religion, sex, sexual orientation, gender, gender identity, age, physical or mental disability, and veteran status.

1 PURPOSE

1.1 This policy and procedure outlines criteria and processes regarding provider-initiated Member Dismissal from Care.

1.2 Provides standards to ensure that members have appropriate access to Primary Care Provider (PCP) and Primary Care Dental (PCD).

2 SCOPE

2.1 This policy applies to Cascade Health Alliance (CHA) members, Providers, Provider Network Management, Member Services, Case Management, and Appeals & Grievances Departments.

3 POLICY STATEMENT

3.1 Members will be treated with respect and with due consideration for his or her dignity and privacy; and not discriminated against on the basis of health status, the need for health services, race, ethnicity, color, national origin, citizenship, religion, sex, sexual orientation, marital status, age, gender, gender identity, physical or mental disability, or veteran status and shall not use any policy or practice that has the effect of discriminating on the basis of race, ethnicity, color, national origin, citizenship, religion, sex, sexual orientation, marital status, age, gender, gender identity physical or mental disability, or veteran status.

3.2 In accordance with OHA Contract, CHA assures that providers shall not request member dismissal from care solely for reasons related to:

3.2.1 An adverse change in the member's health status;

3.2.2 Utilization of medical services;

3.2.3 Diminished physical, intellectual, developmental, or mental capacity

3.2.4 Uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued care seriously impairs the provider/clinic's ability to furnish services to either this particular member or other member).

3.3 Providers may not dismiss members for reasons other than those allowed and referenced in their office policies and procedures.

4 PROCEDURE

4.1 Providers considering member dismissal should contact CHA Compliance for possible mitigation.

4.1.1 CHA Compliance Grievance staff may:

4.1.1.1 Contact member directly to relate concerns and identify access to care issues which may include, but are not limited to, consulting with the following:

4.1.1.1.1 CHA Case Management or other CHA department

4.1.1.1.2 Non-Emergent Transportation (NEMT) services

4.1.1.1.3 Outpatient Care Management (OCM) or Other Traditional Healthcare Worker

4.1.1.1.4 Other social service provider (DHS, ADP, Connection Case Mgt)

4.1.1.2 Notify active member Care Team to contact member to develop plan to resolve issues

4.1.1.3 Care Team may be initiated to work with member in capacity listed above

4.1.1.4 Relate available resources to Provider when appropriate

4.1.2 CHA Compliance Grievance staff must respond to Providers considering member dismissal within 30 days to relate executed mitigation.

4.1.3 In the event prior mitigation of member issue(s) or opportunity to develop resolution plan is not available, Provider may move forward with dismissal from care.

4.2 Provider may dismiss a member from care, per their policies and procedures, without violating OHA Contract.

4.2.1 Dismissal reasons include, but are not limited to:

4.2.1.1 Multiple missed appointments without 24-hour advance notice

4.2.1.1.1 Includes "No Show" for appointments

4.2.1.2 Inappropriate Behavior

4.2.1.2.1 Includes member threats of harm to provider and/or staff

4.2.1.3 Agreement to member's request to cease provider's services

4.3 Providers are required to send written notification of dismissal to member.

4.3.1 Dismissal notice must include the following:

4.3.1.1 Reason for Dismissal

4.3.1.2 Provider to allow visits for 30 days from date of letter to allow for emergent care

4.3.1.3 Access to medical records and how to have them sent to another provider

4.3.1.4 Member direction to contact CHA for provider reassignment

4.4 Provider must send copy of Provider Dismissal of Member notice to CHA Compliance.

4.5 Upon receipt of Provider Dismissal from Care, CHA Compliance Grievance staff will:

4.5.1 Process the Dismissal from Care notice

4.5.1.1 Log the notice in Provider Dismissal from Care Log which includes the following:

4.5.1.1.1 Member ID

4.5.1.1.2 Date of dismissal

4.5.1.1.3 Effective date of termination

4.5.1.1.4 Reason from dismissal

4.5.1.1.5 Provider requesting dismissal

4.5.1.1.6 Reassigned provider

4.5.1.1.7 If member cannot be reached, date of provider un-assignment

4.5.1.2 Attach copy of notice to member's Population Management (PM) file

4.5.1.2.1 Note PM file

4.5.1.3 Contact member

4.5.1.3.1 Note PM file with contact attempts and results

4.5.1.3.1.1 Note reassigned provider with effective date

4.5.1.3.1.2 Process any resulting Grievances

5 RESPONSIBILITIES

Compliance, Monitoring and Review

5.1 The Executive Approval Committee will review this policy and procedure for compliance with OHA contract and guidelines at least once a year, or as applicable.

5.2 The adherence to and monitoring of this policy and procedure may be included in the Compliance department's annual internal audit.

5.3 CHA will include annual training of Provider Dismissal from Care with Annual Provider Training.

Reporting

5.4 Reporting of the number of Provider Dismissals of Member will be shared with CHA Member Services. Quality, and Provider Network Management on at least a quarterly basis.

Records Management

5.5 Team Members must maintain all records relevant to administering this policy and procedure in the recognized record management system.

6 RELATED LEGISLATION AND DOCUMENTS

6.1 Health Insurance Portability and Accountability Act (HIPAA)

6.2 Oregon Health Authority (OHA): Coordinated Care Organizations (CCO)

6.3 Provider Dismissal of Member Desktop Process PP13008

7 FEEDBACK

7.1 Team Members may provide feedback about this document by emailing policyfeedback@cascadecomp.com.

8 APPROVAL AND REVIEW DETAILS

Approval and Review	Details
Advisory Committee to Approval	Executive Approval Committee
Committee Review Dates	[MM/DD/YYYY], [MM/DD/YYYY], [MM/DD/YYYY]
Approval Dates	[MM/DD/YYYY], [MM/DD/YYYY]

9 APPENDIX

9.1 Provider Dismissal from Care Letter Example PP13008.1

Cascade Health Alliance

cascade comprehensive care

PROVIDER DISMISSAL FROM CARE PROCESS

In this document, CCC is referenced in place of CCC and CHA.

1 PURPOSE

1.1 The purpose of this document is to provide details for processing Provider Dismissals from Care

2 SCOPE

2.1 This process document applies to CHA Compliance, Member Services, and Case Management

3 PROCESS

3.1 All documents relating to member dismissal from care or potential dismissal from care are to be directed to Compliance, particularly Compliance Grievance staff.

3.2 Upon receipt of Provider consideration of member for dismissal from care, staff may:

3.2.1 Contact member directly to relate concerns and identify access to care issues which may include, but are not limited to, consulting with the following

3.2.1.1 Discuss needed corrective action with member

3.2.1.2 Refer member to internal or external sources

3.2.1.2.1 Other CHA department

3.2.1.2.2 NEMT

3.2.1.2.3 Outpatient Care Management or Other Traditional Healthcare Worker

3.2.1.2.4 Other social service provider:

3.2.1.2.4.1 DHS, ADP, Connection Case Mgt, etc.

3.2.1.3 Document any actions in Population Management (PM) in

3.2.1.3.1 Attach copy of Provider letters to member in PM

3.2.1.4 Relate available resources to Provider when appropriate

3.2.1.5 Advise notifying Provider of actions taken within 30 days of Provider notice

3.2.1.6 Document steps in Member Dismissal Tracking Log

3.2.1.6.1 Member ID

3.2.1.6.2 Date of dismissal

3.2.1.6.3 Effective date of termination

3.2.1.6.4 Reason from dismissal

3.2.1.6.5 Provider requesting dismissal

3.2.1.6.6 Reassigned provider

3.2.1.6.7 If member cannot be reached, date of provider un-assignment

3.2.1.7 Save copy of Provider documentation in Provider Dismissal of Member folder in Compliance

3.3 Upon receipt of Provider Dismissal from Care

3.3.1 Verify notice to member includes the following :

3.3.1.1 Acceptable reason for dismissal

3.3.1.2 Reason for dismissal

3.3.1.3 Allowance of 30 days from date of letter or emergent care

3.3.1.4 Access to medical records and how to have them sent to another provider

3.3.1.5 Member was directed to contact CHA for provider reassignment (unless dismissal is not for PCP or PCD care)

3.3.2 Document any actions in Population Management (PM) in

3.3.2.1 Request applicable reassignment requests to Member Services

3.3.2.2 Attach copy of Provider letters to member in PM

3.3.3 Document steps in Member Dismissal Tracking Log

3.3.3.1 Provider Dismissal from Care Log which includes the following:

3.3.3.1.1 Member ID

3.3.3.1.2 Date of dismissal

3.3.3.1.3 Effective date of termination

3.3.3.1.4 Reason from dismissal

3.3.3.1.5 Provider requesting dismissal

3.3.3.1.6 Reassigned provider

3.3.3.1.7 If member cannot be reached, date of provider un-assignment

3.3.4 Save copy of Provider documentation in Provider Dismissal of Member folder in Compliance

3.4 Process any resulting Grievances

DATE

ADDRESS
ADDRESS
ADDRESS

MEMBER ID#

Dear Member,

Effective DATE, CLINIC NAME will be unable to serve as your (Primary Care Provider/Primary Care Dentist/Dental Care Provider) under your Oregon Health Plan. (ENTER REASON IF APPLICABLE). We ask that you call Cascade Health Alliance Member Services at 541-883-2947 to be assigned to a new (Primary Care Dentist/Dental Care Provider).

Our office will continue to be available to you for emergency care for a period of up to 30 days while you are seeking other (Primary Care/Primary Dental Care) services.

If you wish to have copies of your care records and x-rays, please contact our office CONTACT INFO to let us know the new (Primary Care Provider/Primary Dental Care Provider) that will be providing your care.

If you have any questions about this letter, please call CHA Member Services at 541-883-2947.

Sincerely,

NAME/CLINIC/Manager

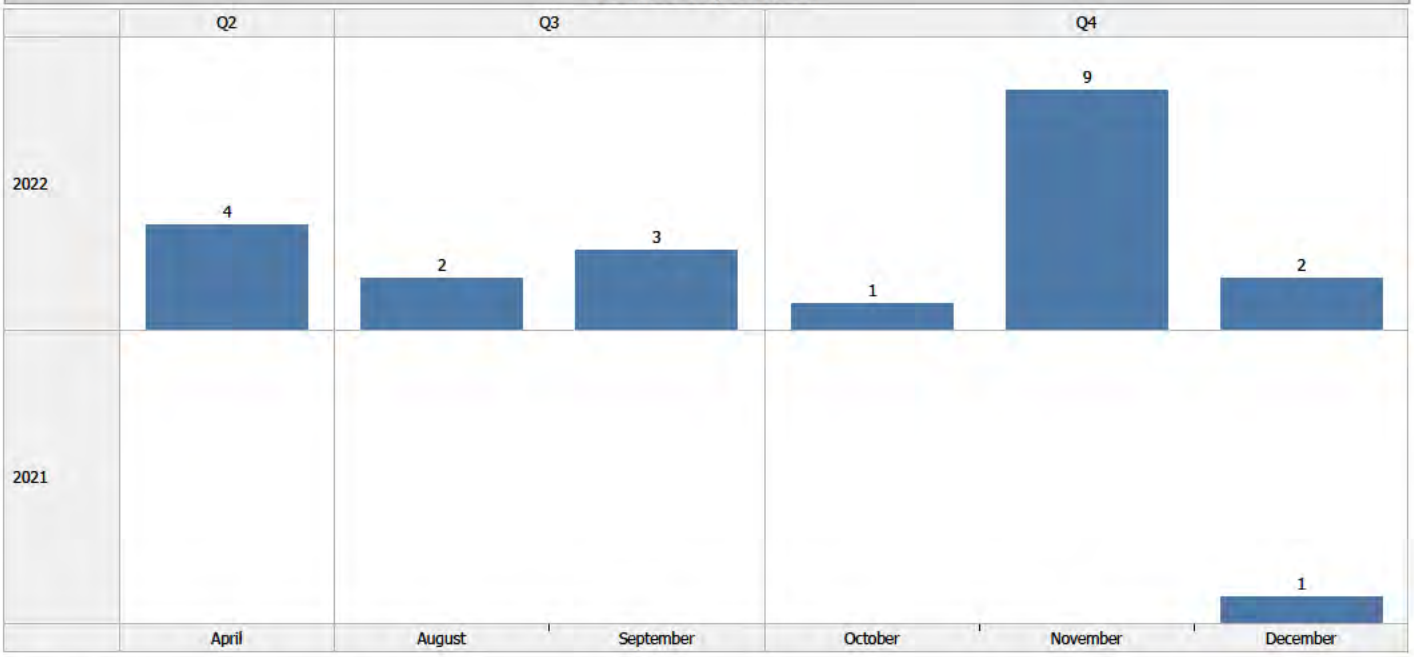
PROVIDER DISMISSAL DASHBOARD

Cascade Health Alliance

March 2023
Kim Walls

Total Dismissal Count	Total Reassigned	Total Unassigned	Number of Grievences
22	10	12	1

Dismissals per Month



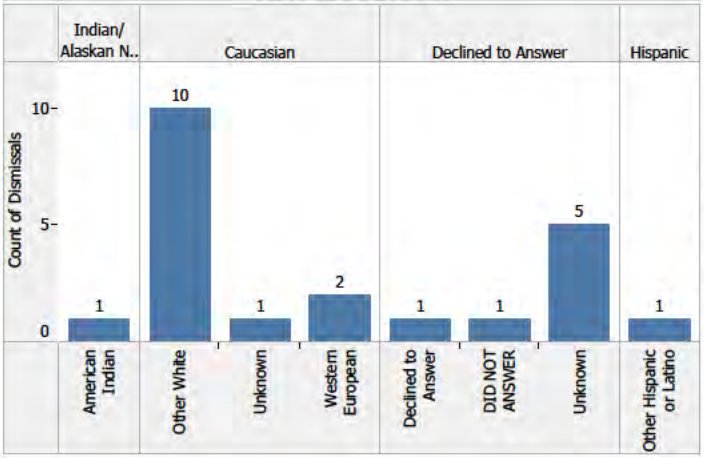
Data Notes: 12/4/2021-12/27/2022 **Extracted:** 3/2/2023 **Source:**

PROVIDER DISMISSAL DASHBOARD

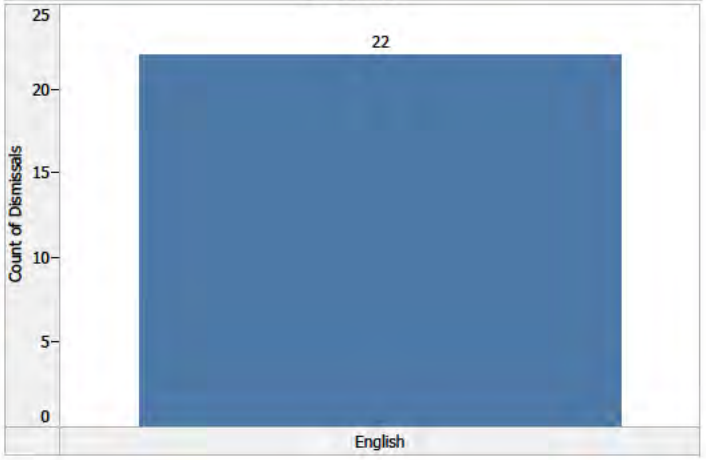
Cascade Health Alliance

March 2023
Kim Walls

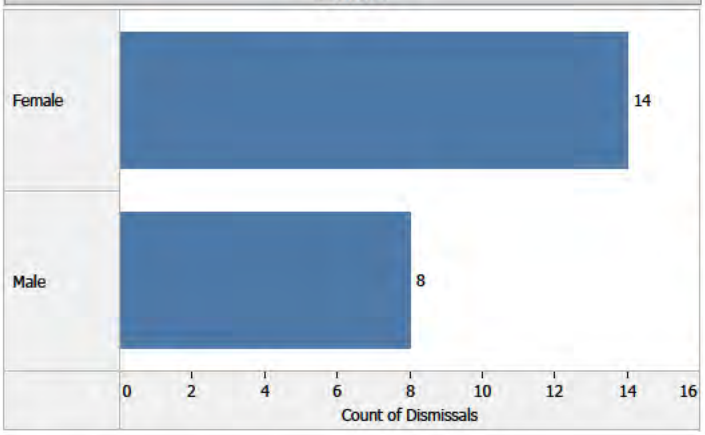
Race and Ethnicity



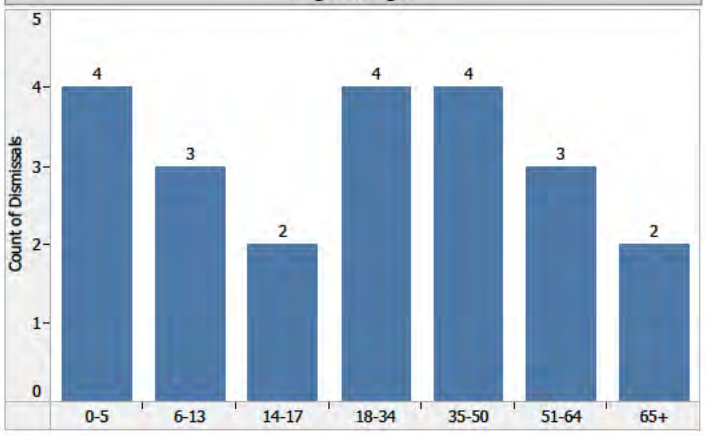
Language



Gender



Age Range

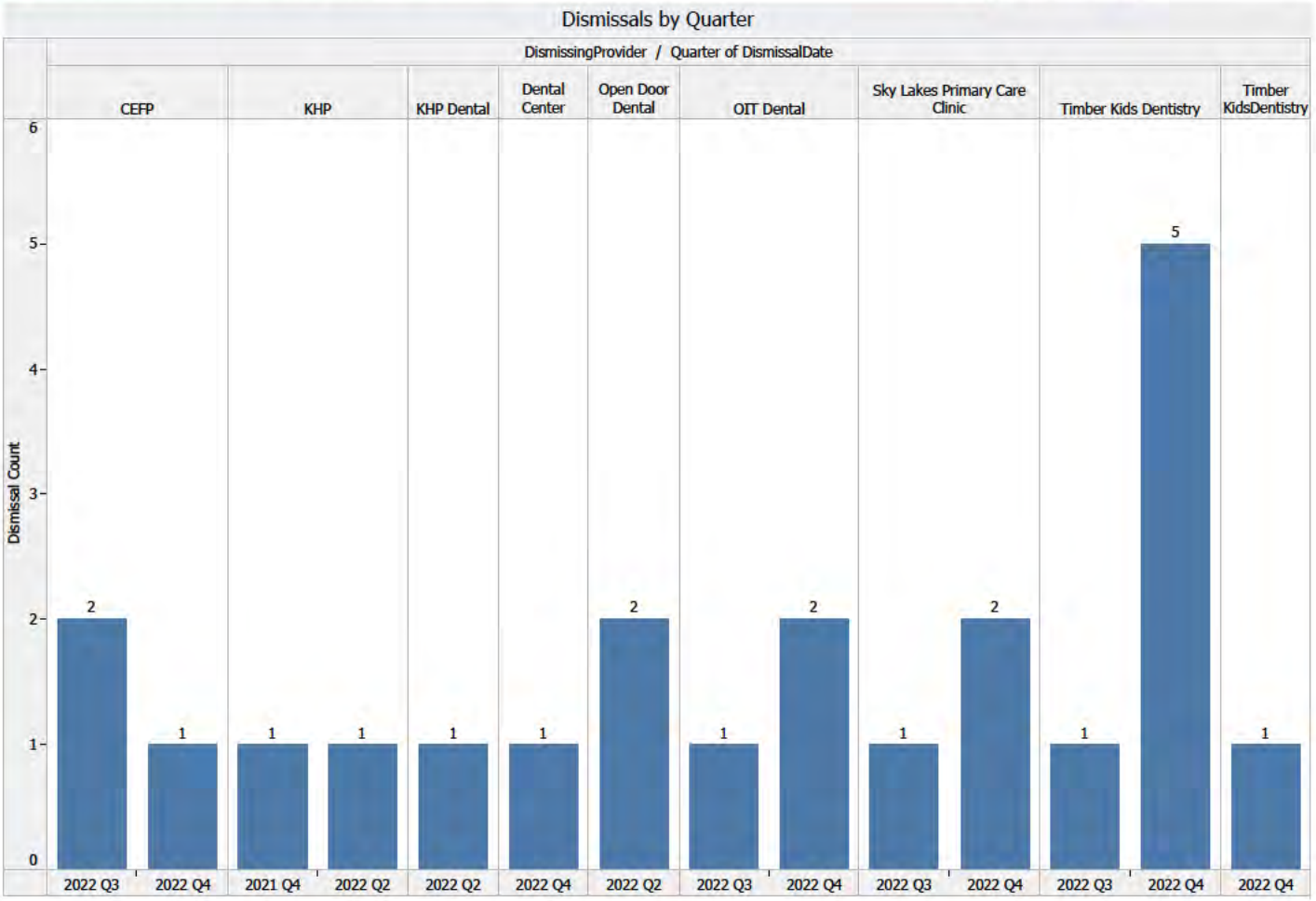


Data Notes: 12/4/2021-12/27/2022 **Extracted:** 3/2/2023 **Source:**

PROVIDER DISMISSAL DASHBOARD

Cascade Health Alliance

March 2023
Kim Walls



Data Notes: 12/4/2021-12/27/2022 **Extracted:** 3/2/2023 **Source:**

PROVIDER DISMISSAL DASHBOARD

Cascade Health Alliance

March 2023
Kim Walls

DISMISSALS

Total Dismissal Count: The total amount of dismissals.

Total Reassigned: The amount of dismissals that were reassigned.

Number of Grievances: The number of dismissals that have grievances attached.

Dismissals per Month: A month by month breakdown of the amount of dismissals.

DEMOGRAPHICS

Race and Ethinicity: A breakdown of the race and ethnicity of the member that is associated with the dismissal.

Language: A breakdown of the speak language of the member that is associated with the dismissal.

Gender: A breakdown of the gender of the member that is associated with the dismissal.

Age Range: A 6 bucket breakdown of the ages of the dismissals.

DISMISSALS BY PROVIDER

This displays the amount of dismissals seperated by provider and per quarter.

Cascade Health Alliance

Introduction to Healthy Klamath Connect: Virtual Community Event

› RSVP here

Join Cascade Health Alliance and findhelp to learn about Healthy Klamath Connect and our shared vision to create direct connections to local services and assistance for the residents of Klamath County.

Event Details

December 7, 2022

2pm - 3pm, Pacific Time
Virtual Event
Pre-registration required

Questions?
Allyn Cripe
Community Engagement Manager, findhelp
acripe@findhelp.com

What You'll Learn

- How to search for and connect people to resources
- How to send and track your referrals
- How to claim your program & join the Healthy Klamath Connect network
- How to manage your program listings and collaborate with your team

Facilitators

Justin Straus
Marketing and Communications Manager, Cascade Health Alliance

Patricia Pahl
Health Equity Manager, Cascade Health Alliance

Allyn Cripe
Community Engagement Manager, findhelp

In Partnership With

findhelp

About findhelp

At **findhelp**, we connect people with local nonprofits offering social services, and we support organizations with tools that help them provide the best service. See what's going on in your area!

› RSVP here

OHA Project #33

Need help?
Find help.

Search community resources at HealthyKlamathConnect.com

OHA Project #33

Find and connect with services for:

Health

Food

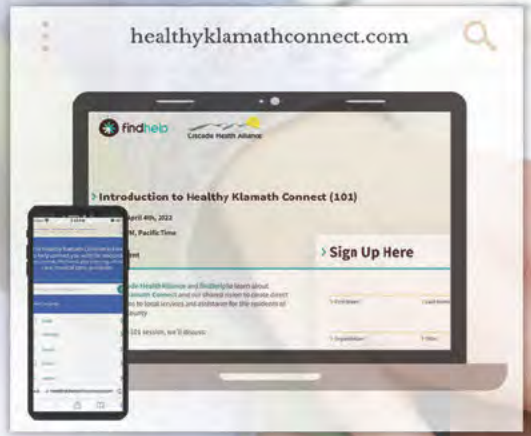
Housing

Transit

Employment

And much, much more...

HealthyKlamathConnect.com



OHA Project #33

¿Necesita ayuda? Encuéntrela.

HEALTHY KLAMATH

Cascade Health Alliance

Busque recursos de la comunidad en HealthyKlamathConnect.com

OHA Project #33

Encuentre y acceda a los servicios de:

Salud

Nutrición

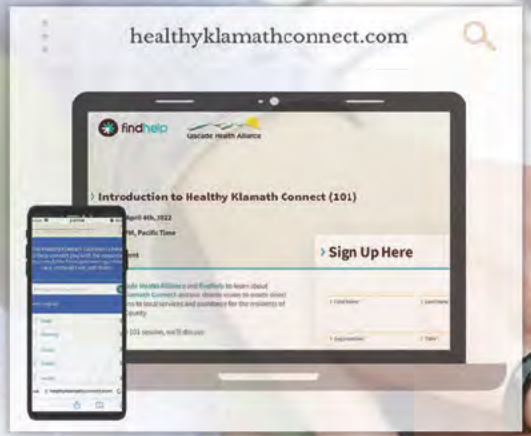
Vivienda

Transporte

Empleo

Y mucho, mucho más…

HealthyKlamathConnect.com



OHA Project #33

findhelp

Cascade Health Alliance

Introduction to Healthy Klamath Connect

December 7th, 2022

Welcome! While we wait for everyone to join, please use the chat function to:

- **Introduce yourself**
- **Share your organization & role**

OHA Project #33

Today's Speakers

Justin Straus
Marketing and
Communications Manager
Cascade Health Alliance

Patricia Pahl
Health Equity Manager
Cascade Health Alliance

Allyn Cripe
Oregon Community
Engagement Manager
findhelp

Agenda

- What is **Healthy Klamath Connect**?
- How to use **healthyklamathconnect.com**
- Key takeaways
- Next steps

Certifications

Take your knowledge to the next level by becoming findhelp.org **Certified**! After you take both the 101 and 201 courses, we'll send you short quizzes. Pass both quizzes and you'll be certified!

You'll receive:

- Access to our online community of other professional Navigators
- A certification badge to add to your LinkedIn profile and website
- Opportunities to speak on panels in partnership with findhelp.org
- Additional 1:1 support from your CEM

- **POLL:** How much do you know about healthyklamathconnect.com?

Cascade Comprehensive Care (CCC) & Cascade Health Alliance (CHA)

Cascade Comprehensive Care is a health care management company founded in 1992 to create health care access for Klamath County residents

CCC operates Cascade Health Alliance, Klamath County's coordinated care organization (CCO) through a contract with the Oregon Health Authority

cascade comprehensive care

Cascade Health Alliance

Cascade Comprehensive Care (CCC) & Cascade Health Alliance (CHA)

Our Vision: To build a healthy community for the population we serve

Our Mission: To improve the health of our members by joining with our community partners to advocate for reliable, accessible and high-quality health care that empowers the people who live in our community to improve their health and well-being.

We currently serve about 25,000 Medicaid members and 5,000 Medicare members.

cascade comprehensive care

Cascade Health Alliance

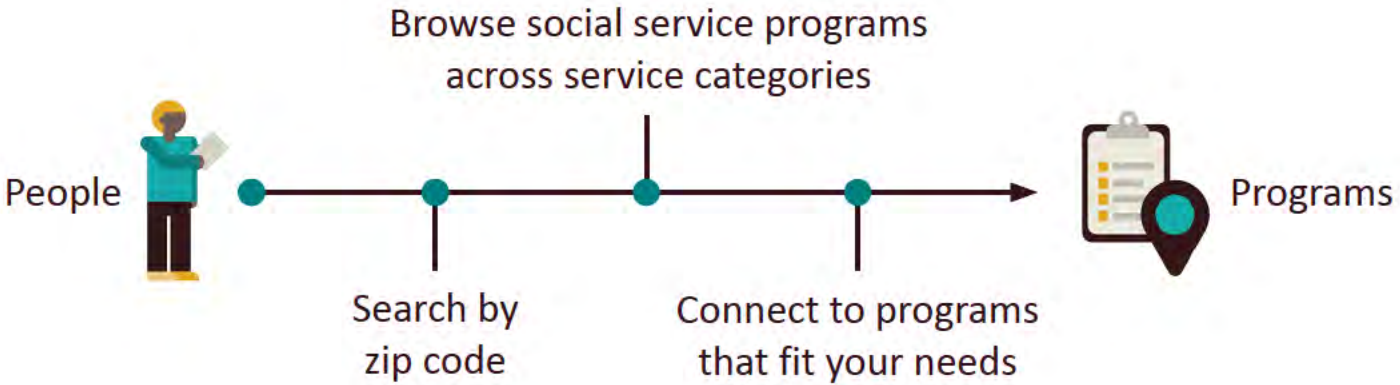
Our Shared Vision:

HEALTHY KLAMATH

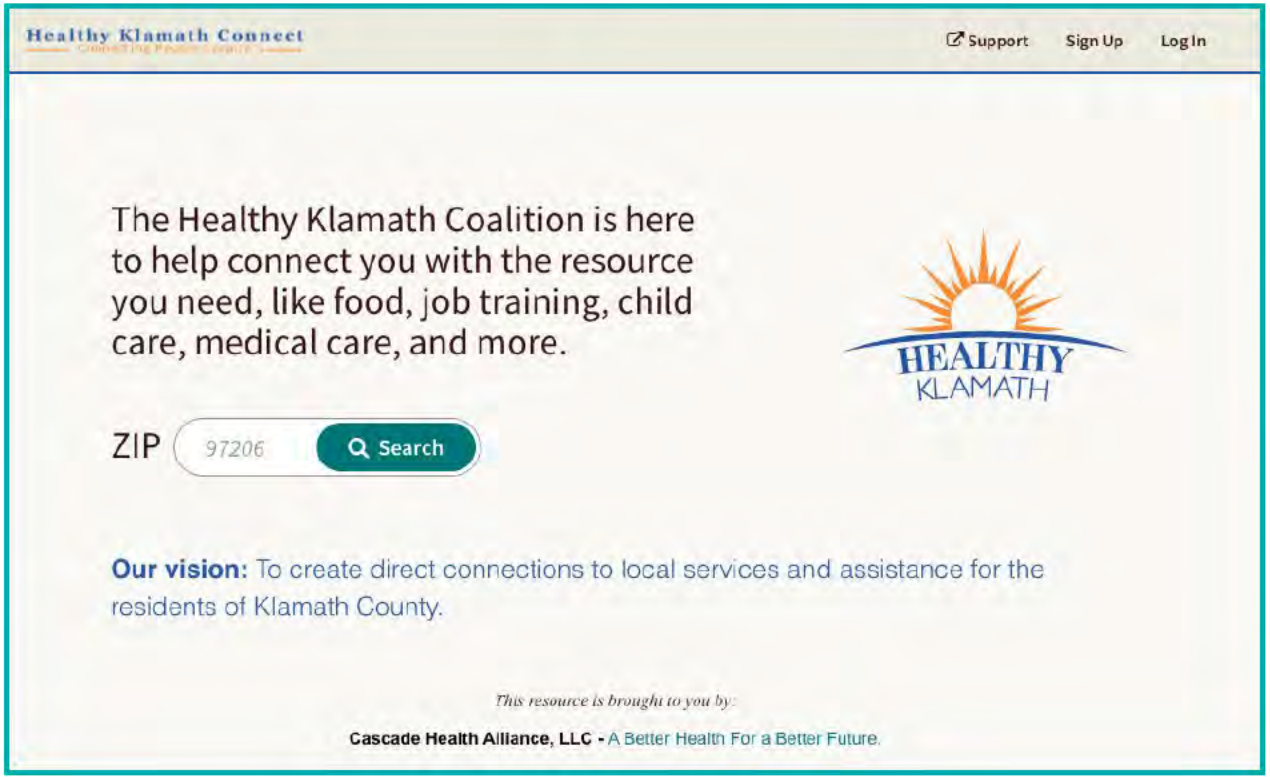
To create direct connections to local services and assistance for the residents of Klamath County.

It’s too hard to navigate the system.

We’re trying to make it easier.

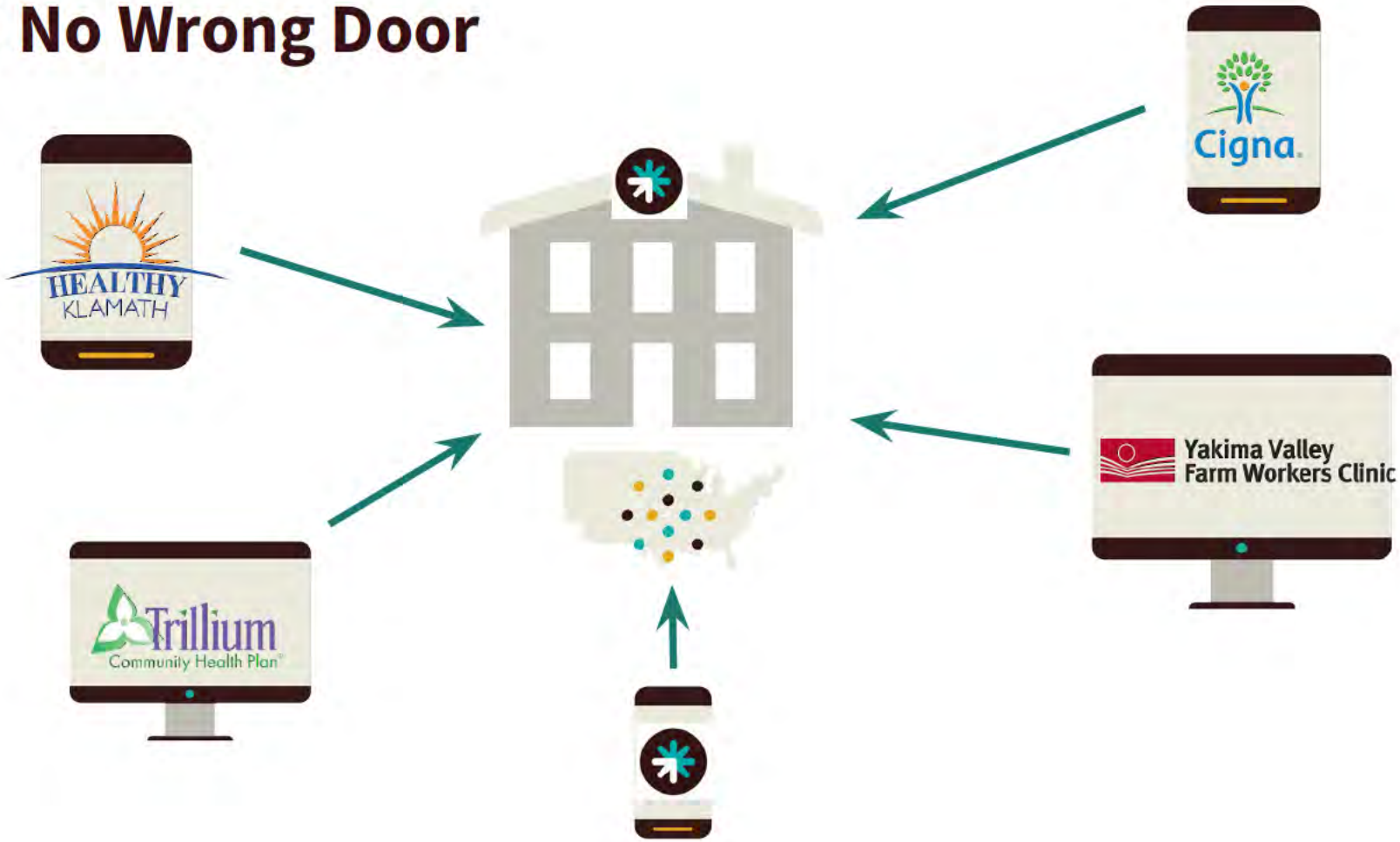


What is healthyklamathconnect.com?



- Online directory of free and reduced-cost services;
- Free to those looking for help;
- Free for nonprofits to manage their programs;
- Over 1,500 programs in local zip codes

No Wrong Door

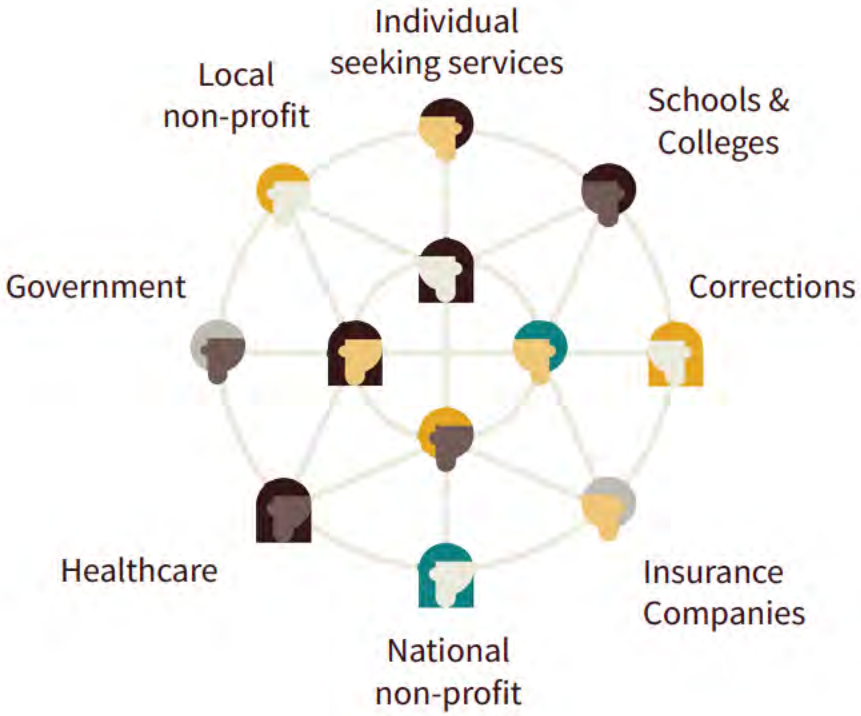


Benefits of using healthyklamathconnect.com

Open Network. We're here anywhere and anytime across the U.S.

Private and secure. We're HIPAA & FERPA Compliant and HITRUST Certified.

Flexibility. The tool is easy to use and is meant to help those in need and the organizations that serve them.



What's uniquely available for organizations?

We offer a free suite of program management tools and impact reports and tailored support for organizations.

We help people connect with your services in a way that makes sense for you, not the other way around.

Program Claiming

Claiming allows people to take ownership of their program listing(s) on the network.

Frequently Asked Questions

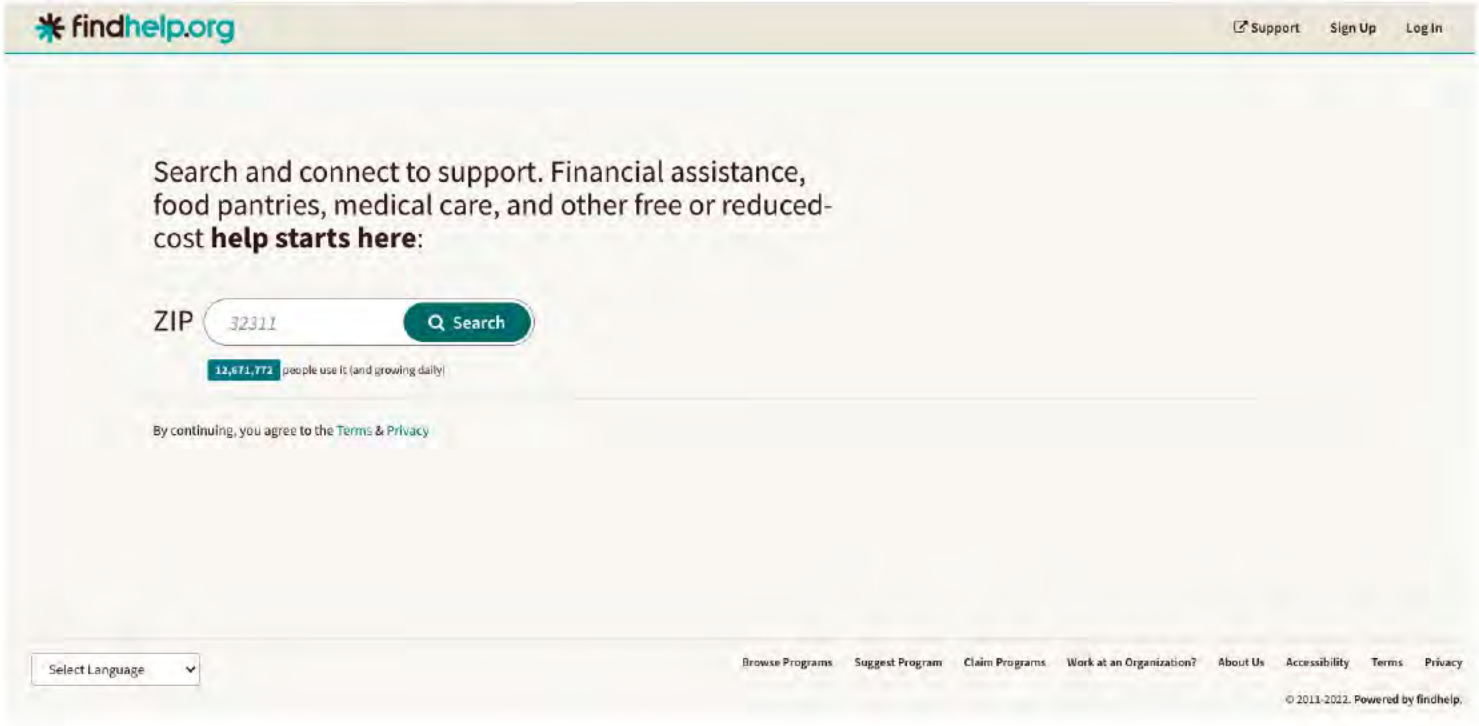
- What are the benefits of claiming?
- How many people can claim a program?
- Which program tools should I use?

healthyklamathconnect.com/claims

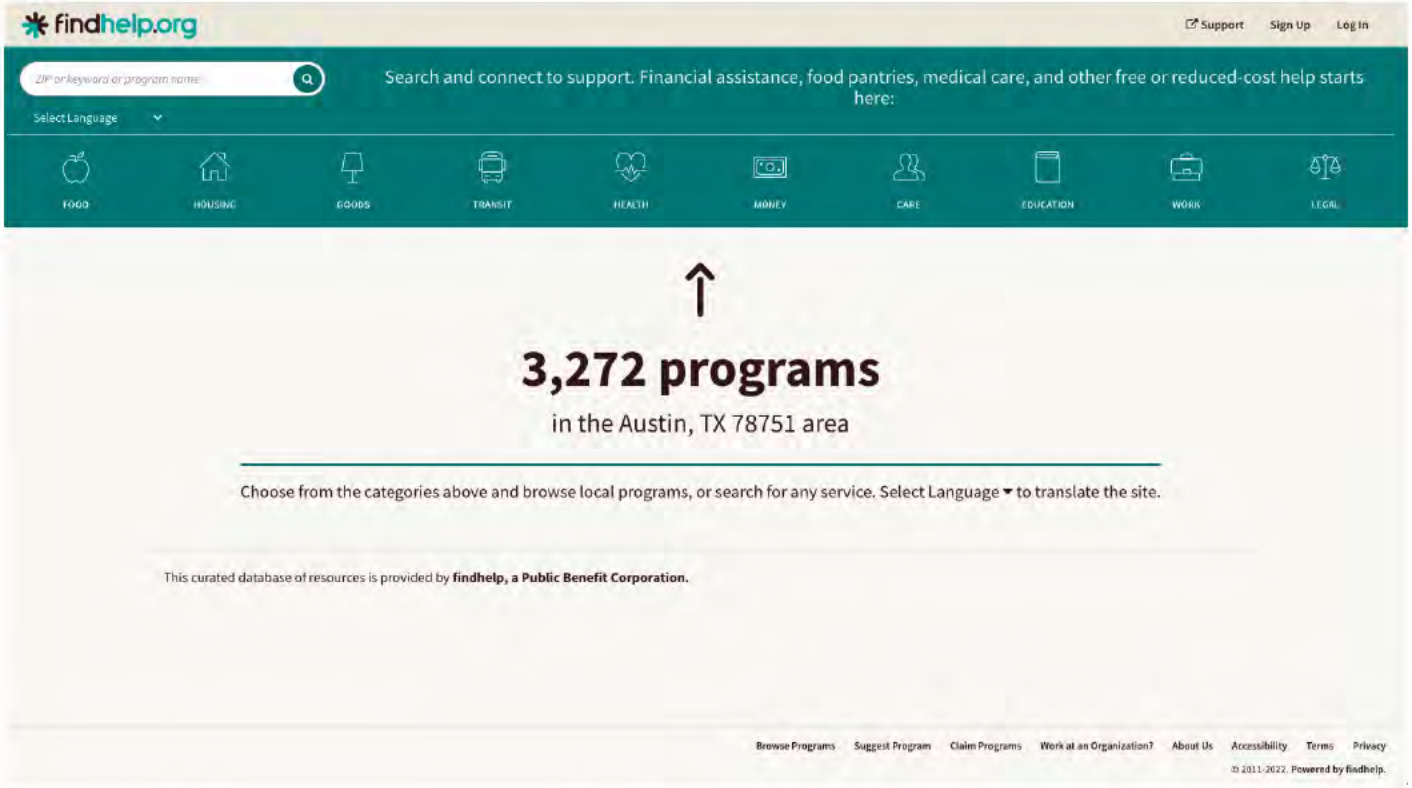
How to use healthyklamathconnect.com

Connecting to Resources

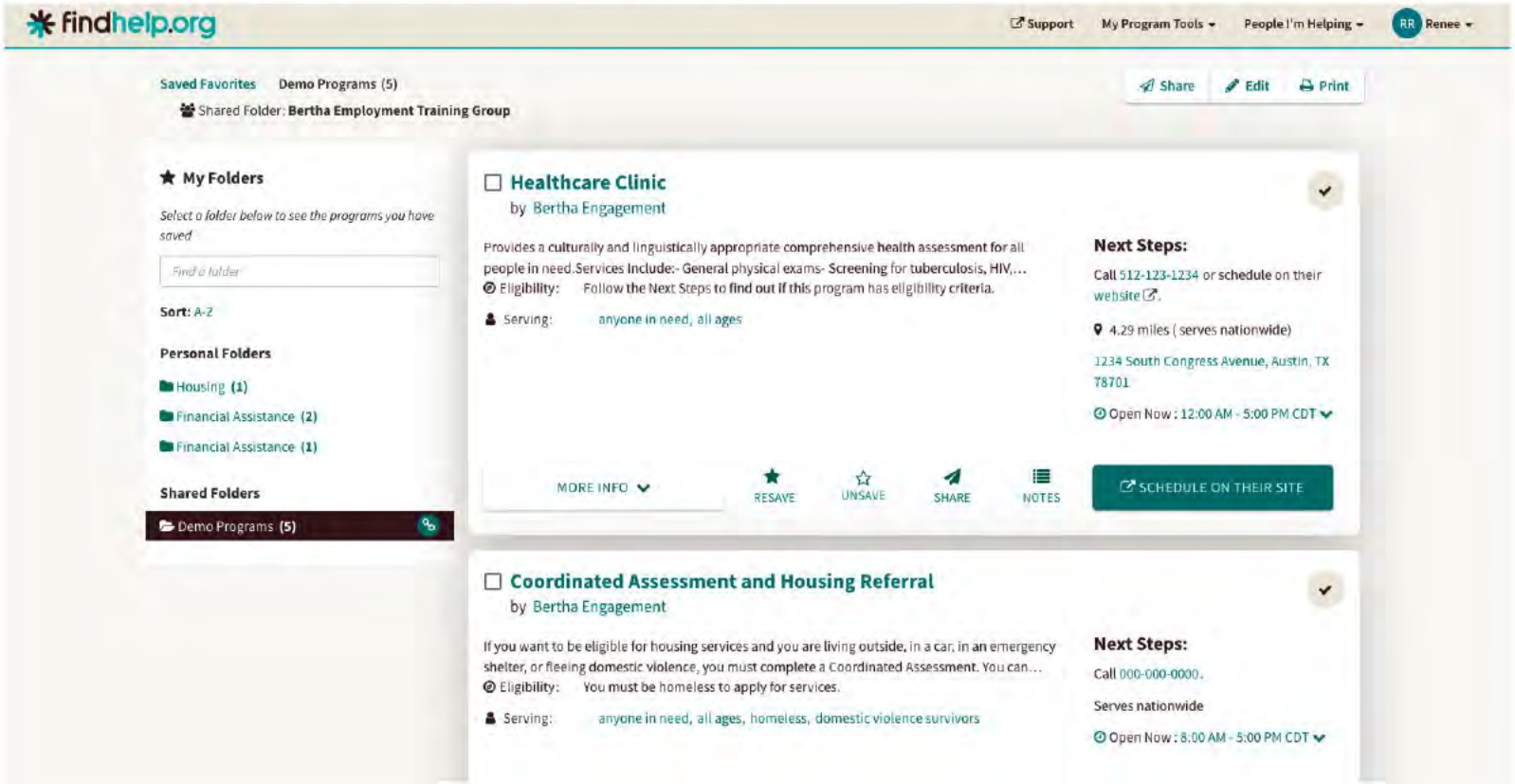
Search for programs



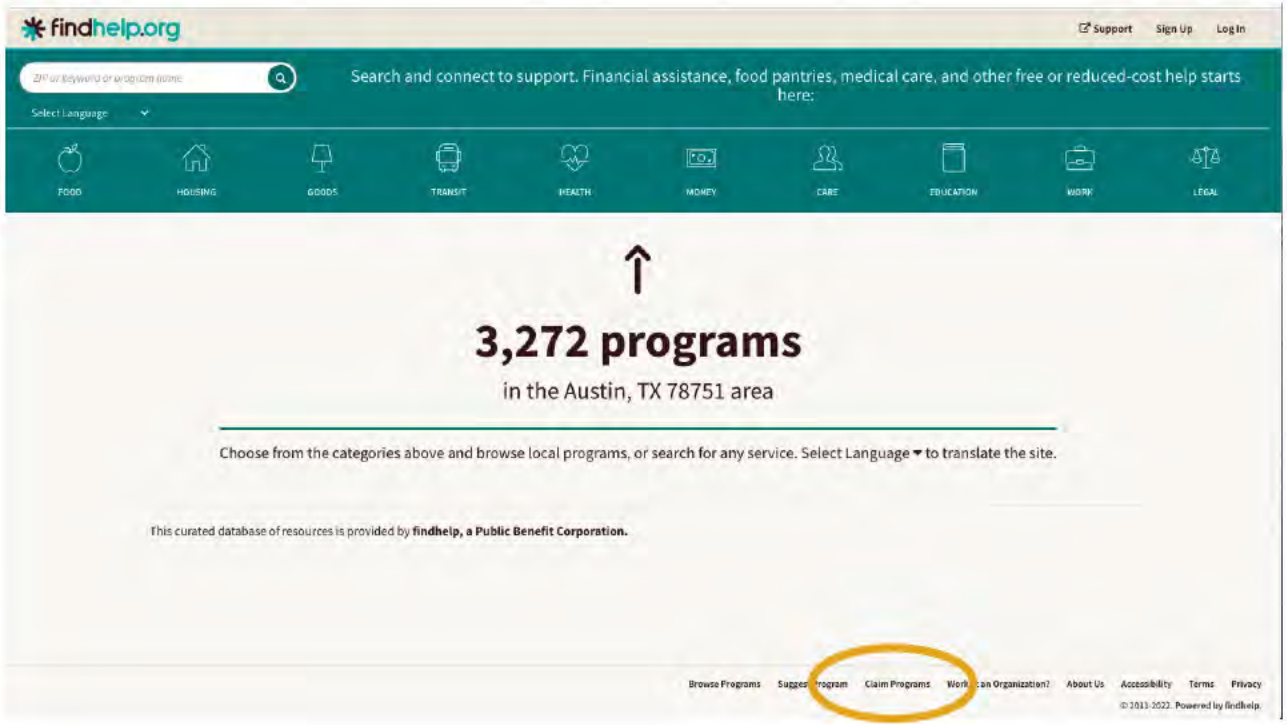
Browse social service programs



Create favorites folders



Claim your program(s) now! (demo)



Program Analytics

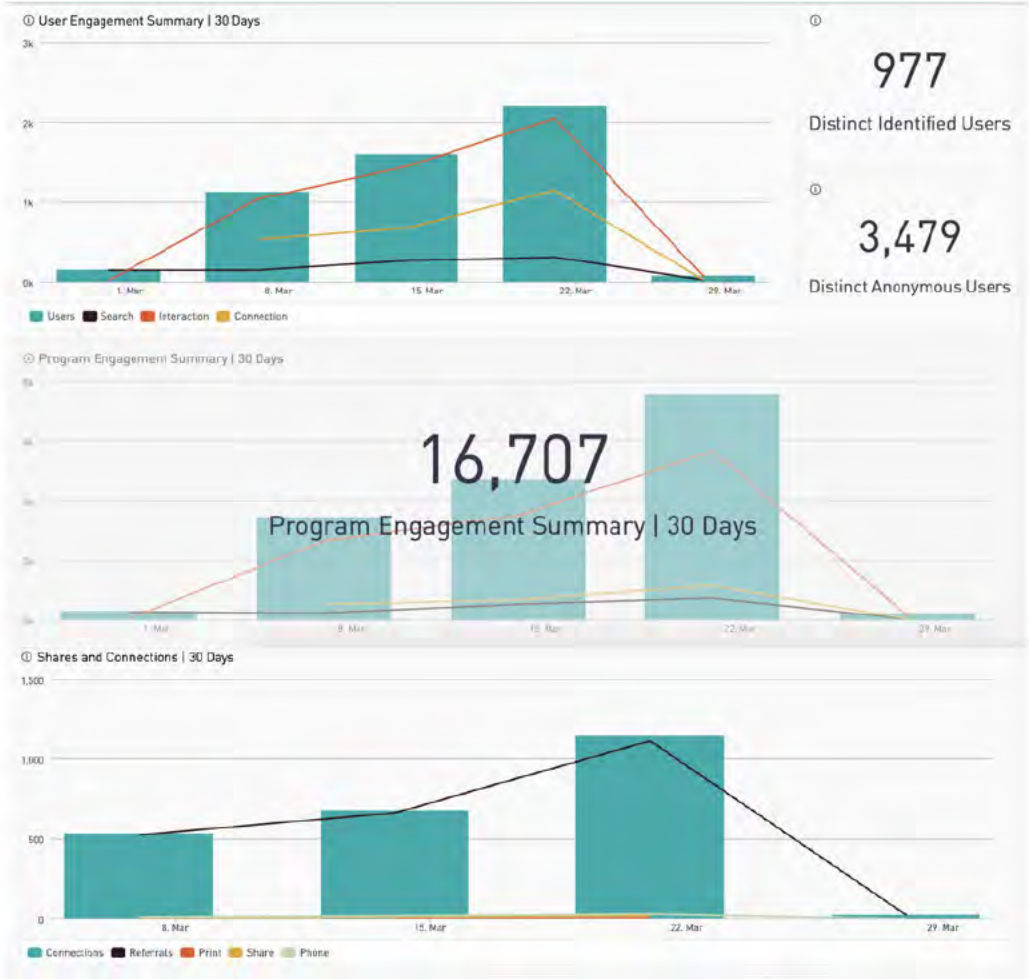
Analytics: Claimed Program Dashboard

Measure your impact and program engagement!

Use this Dashboard to:

- Quantify all the different ways people are **interacting with your programs;**
- **Show your program's scope** in program evaluations, grants and fundraising, and external reporting to funders and/or regulators;
- **Show impact** through Referral data highlights effectiveness;
- Demonstrate the need for **additional resources or staff.**

Claimed Program Dashboard



Claimed Program Dashboard

ⓘ Top 10 Counties | 30 Days

COUNTY	REFERRALS
San Bernardino, CA	1,598
Riverside, CA	719

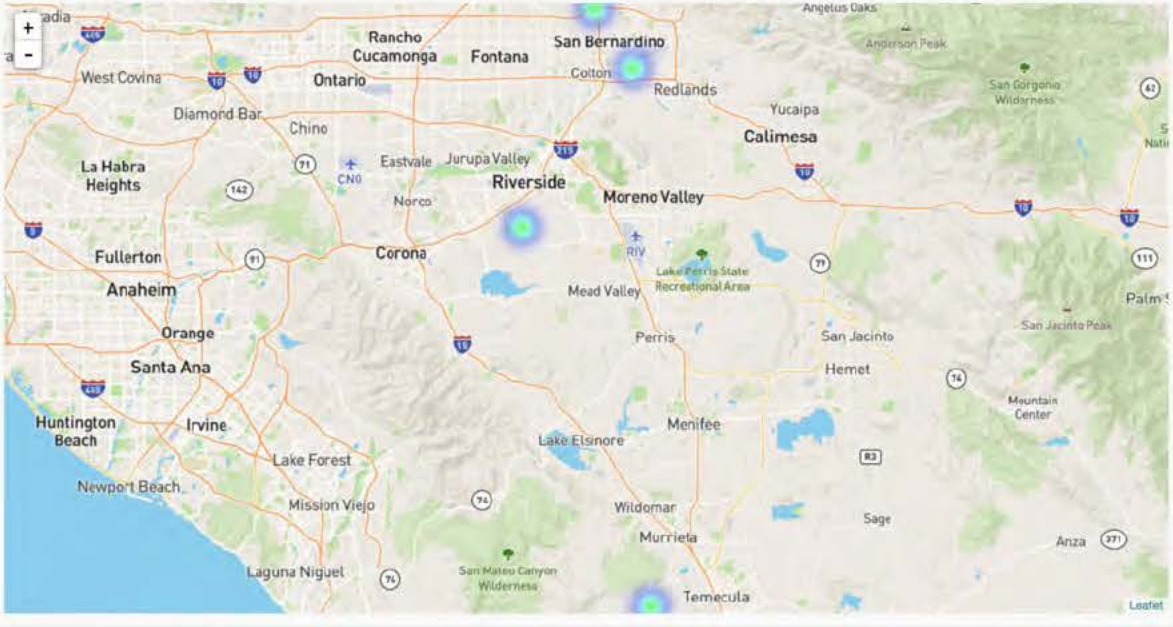
ⓘ Top 10 Cities | 30 Days

CITY	REFERRALS
San Bernardino, CA	1,598
Riverside, CA	711
Temecula, CA	8

ⓘ Top 10 Zip Codes | 30 Days

ZIP CODE	CITY	REFERRALS
92405	San Bernardino, CA	1,145
92504	Riverside, CA	711
92408	San Bernardino, CA	453
92590	Temecula, CA	8

ⓘ Referrals Heat Map | 30 Days

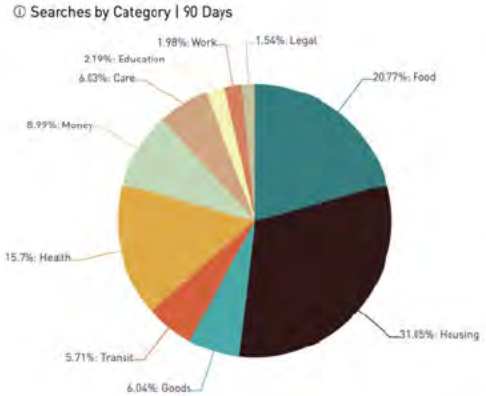


Intake Tools Dashboard

Referral Details | 90 Days

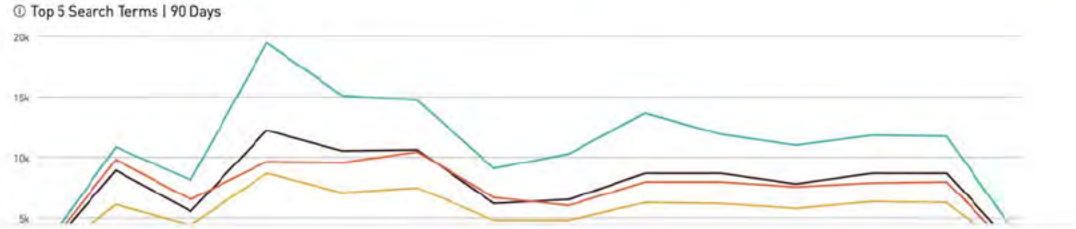
SEEKER NAME	SEEKER PHONE NUMBER	SEEKER EMAIL	SEEKER USERENAME	SENDER EMAIL
Sheena Tallthere	234-567-8901		2345678901_sheena_tallthere	aschulte@nebraskahealthnetwork.com
Karen Roller		karenlroller@gmail.com	karenlroller@gmail.com	karenlroller@gmail.com
Jon Doe		jondoe@gmail.com	jondoe@gmail.com	aschulte@nebraskahealthnetwork.com
Lehua Gray		lehua.gray+seekerexample3679@gmail.com	lehua.gray+seekerexample3679@gmail.com	lehua.gray+seekerexample3679@gmai
Jess Johnson	615-594-1517	jjohnson+demo@auntbertha.com	jjohnson+demo@auntbertha.com	surelyyoujesst@gmail.com

Search Trends In Your Area Dashboard



Most Common Search Terms | 90 Days

TERM	DOMAIN	SEARCHES
help pay for housing	housing	155,039
undefined		118,603
food pantry	food	109,084
help pay for utilities	housing	106,535
help find housing	housing	78,041
emergency food	food	64,589
food delivery	food	62,081
financial assistance	money	48,543
help pay for food	food	43,957
government food benefits	food	37,521
help pay for internet or phone	housing	37,019
housing vouchers	housing	33,195
transportation	transit	31,686
temporary shelter	housing	28,420
transportation for healthcare	transit	28,042



Data Collection Form Report

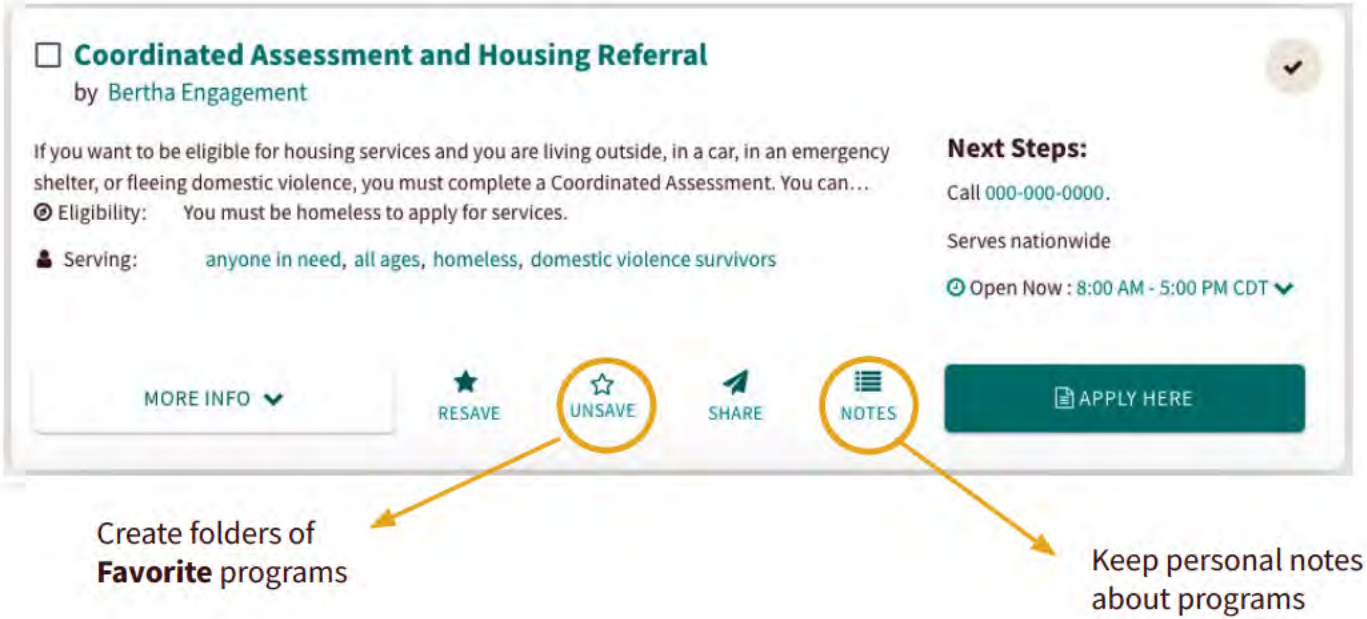
CBO Data Collection Form Details | 90 Days

CREATED AT	FIRST NAME	LAST NAME	QUESTION	ANSWER
2021-04-21	Aaron	Fakename	Annual Family Income	$10,001 - $25,000
2021-04-21	Aaron	Fakename	Services Provided	Rent Assistance
2021-04-21	Aaron	Fakename	Total dollars granted	4,000

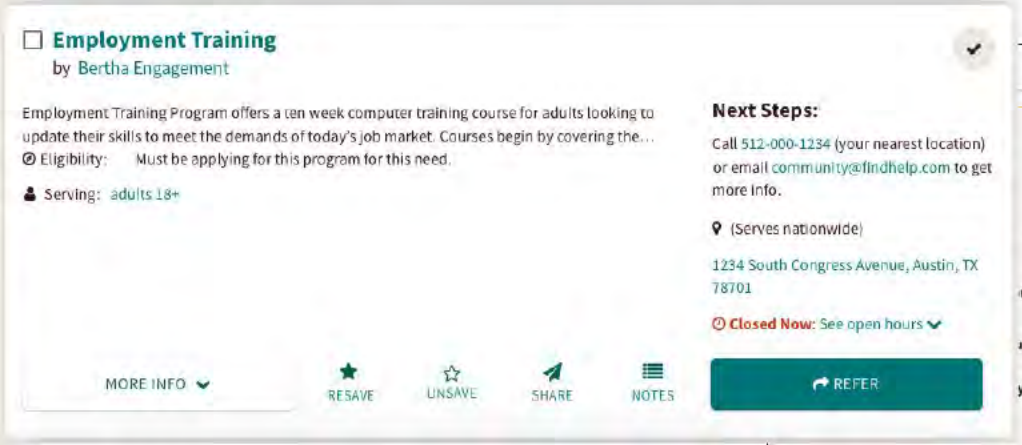
Edit Pivot
Search
Download Data
290 Rows

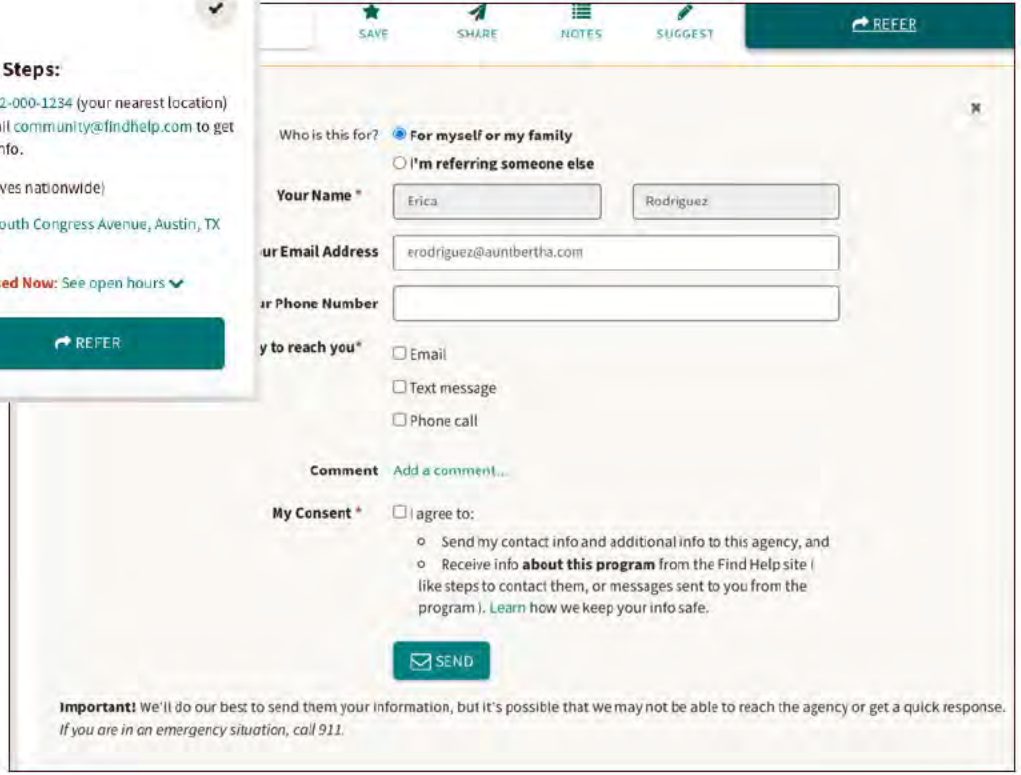
Key Takeaways

Interact with programs

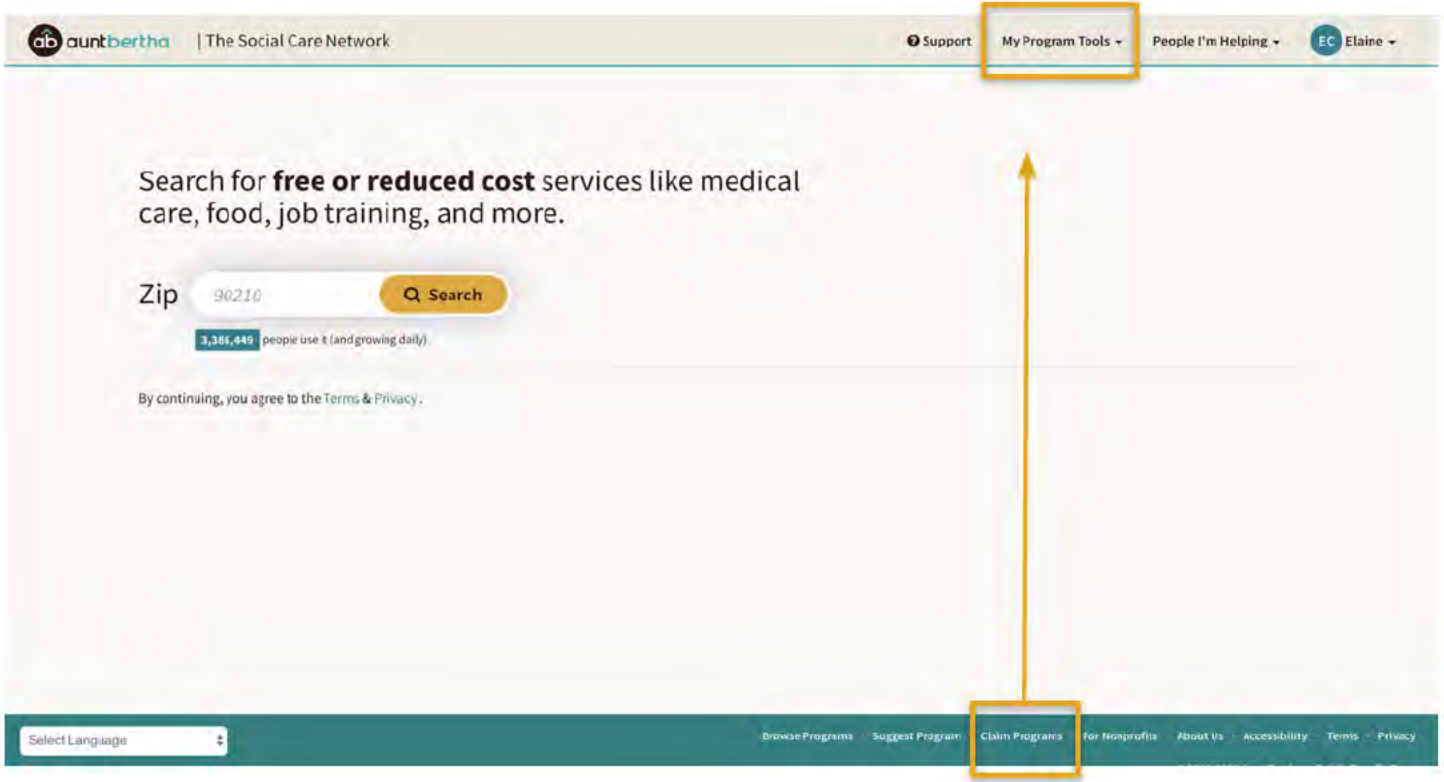


Refer to programs

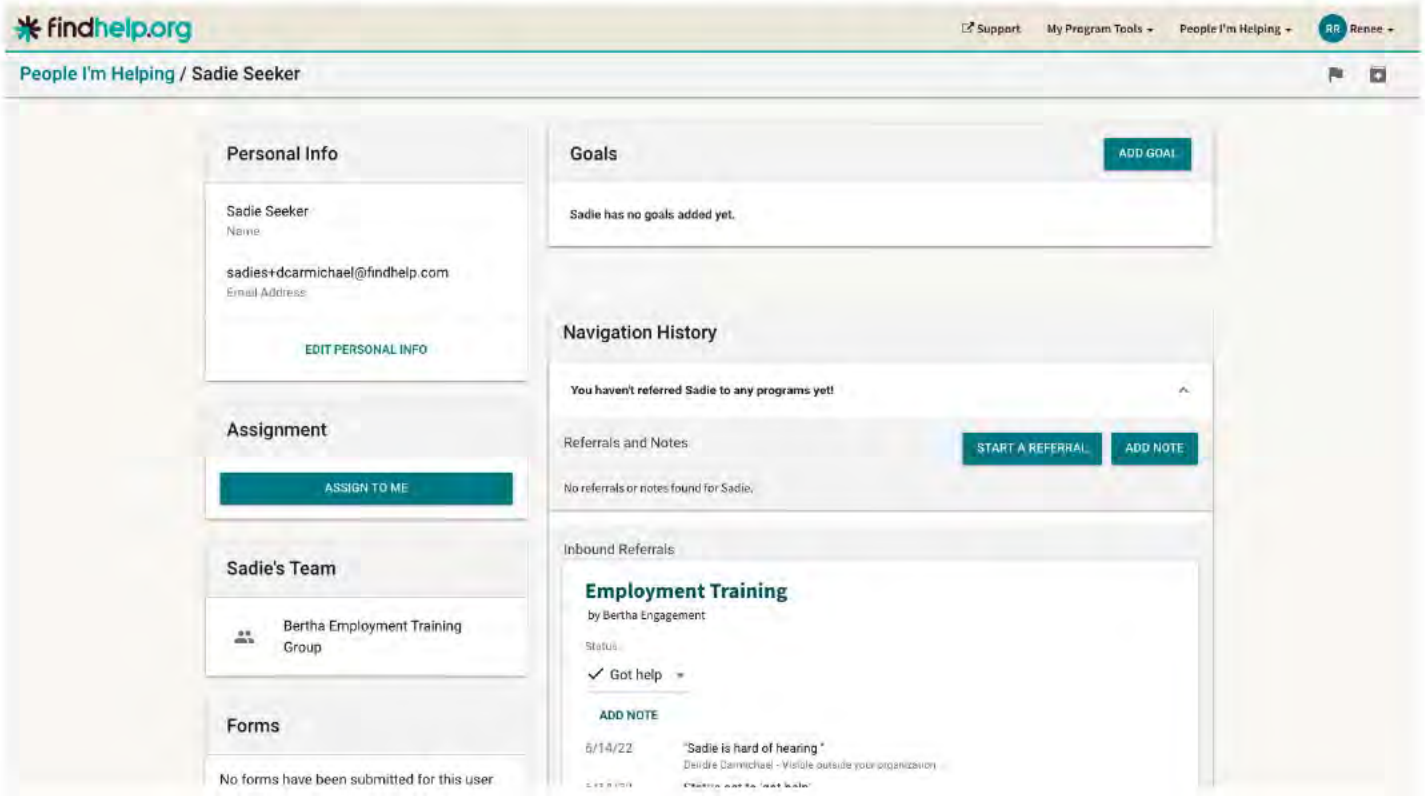




Access your free suite of tools

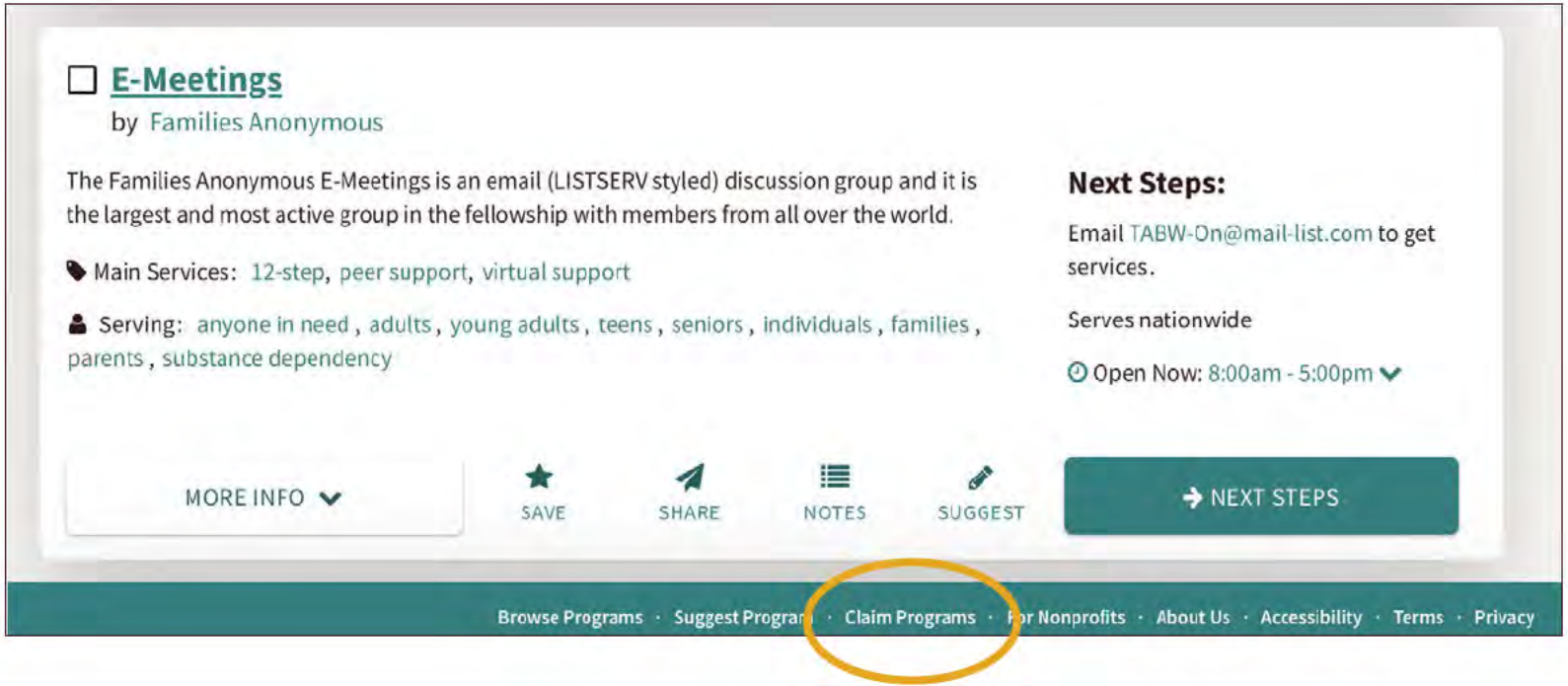


Manage people you're helping



Next Steps

Claim your program(s)



Select an intake tool that fits your needs

- Pass along their name, phone, and email address with One-Step Referrals (free, default)
- Gather more info about eligibility with a customized Screening Form (free)
- Let them schedule an appointment (free, must set up available times)
- This program can't help people who make contact through Aunt Bertha
- We want to link them to an existing application, scheduler, or contact form

Get Certified!

Collaborate and partner with like-minded professionals by becoming findhelp.org Certified.

You'll receive:

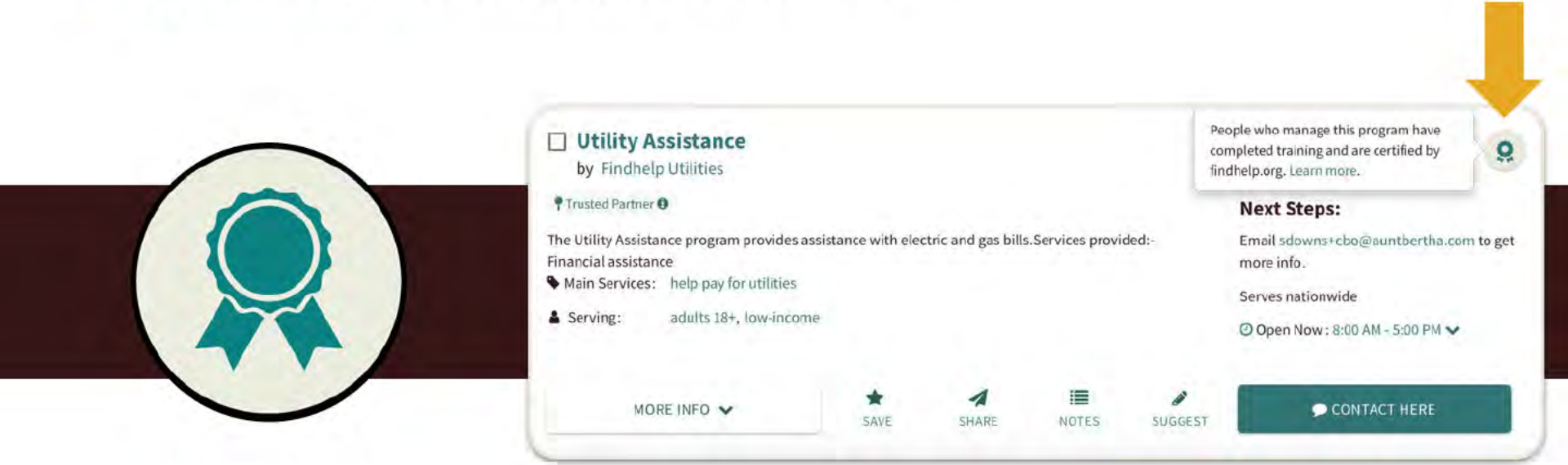
- Membership to our online community;
- Additional 1:1 support with your dedicated CEM;
- Speaking opportunities in partnership with findhelp.org;
- Certification badge to add to website and professional networks.

Simply take the quiz after this training!

Certification Icon

NEW! 2022

- **Certified program claimers** will have this icon on their program(s)
- **Certified programs** display higher in search results



→ Organization Spotlight: Sky Lakes Outpatient Care Management

Let's Connect!

Justin Straus
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Allyn Cripe
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findhelp
acripe@findhelp.com
Book a Meeting

Questions?

SDOH Screening and Referral OHA Incentive Metric

August 2022

https://healthyklamathconnect.com/
https://www.oregon.gov/oha/HSD/AMH/Pages/SDOH.aspx
https://www.oregon.gov/oha/hpa/analytics/pages/cco-metrics.aspx
https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/sdoh-measure.aspx

OHA Project #61, #33

Cascade Health Alliance

Social Determinants of Health (SDOH)

Social determinants of health (SDOH) are conditions in the places where people live, learn, work, and play can affect a wide range of health risks and outcomes.

Centers for Disease Control and Prevention (CDC)
https://www.cdc.gov/socialdeterminants/index.htm

As of March 8, 2022, nearly half of OHP members have one or more social needs according to OHA. Communities of color are disproportionally affected.

Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved August 1, 2022 from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

How does a screening & referral measure get us to our goals?

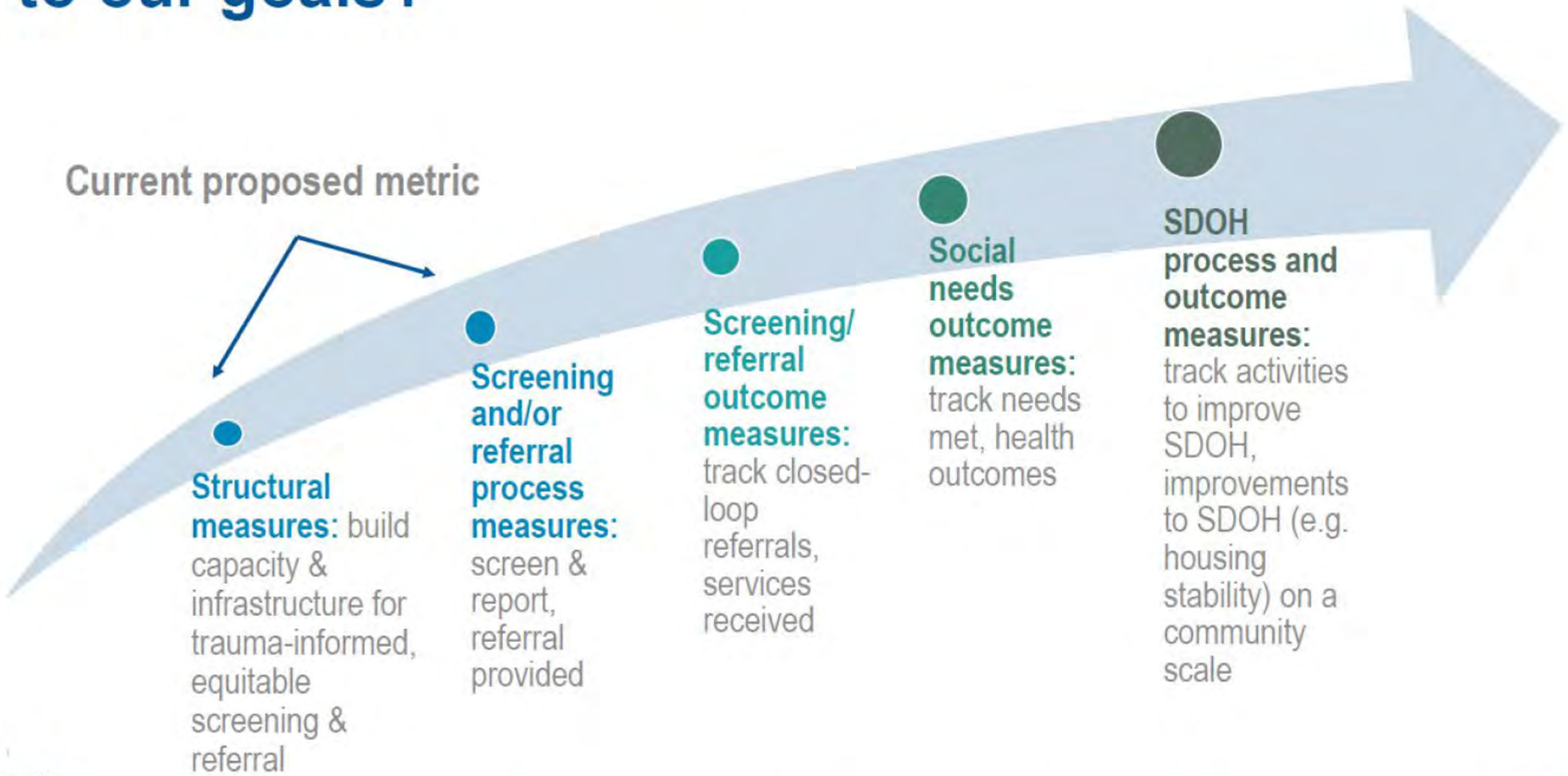
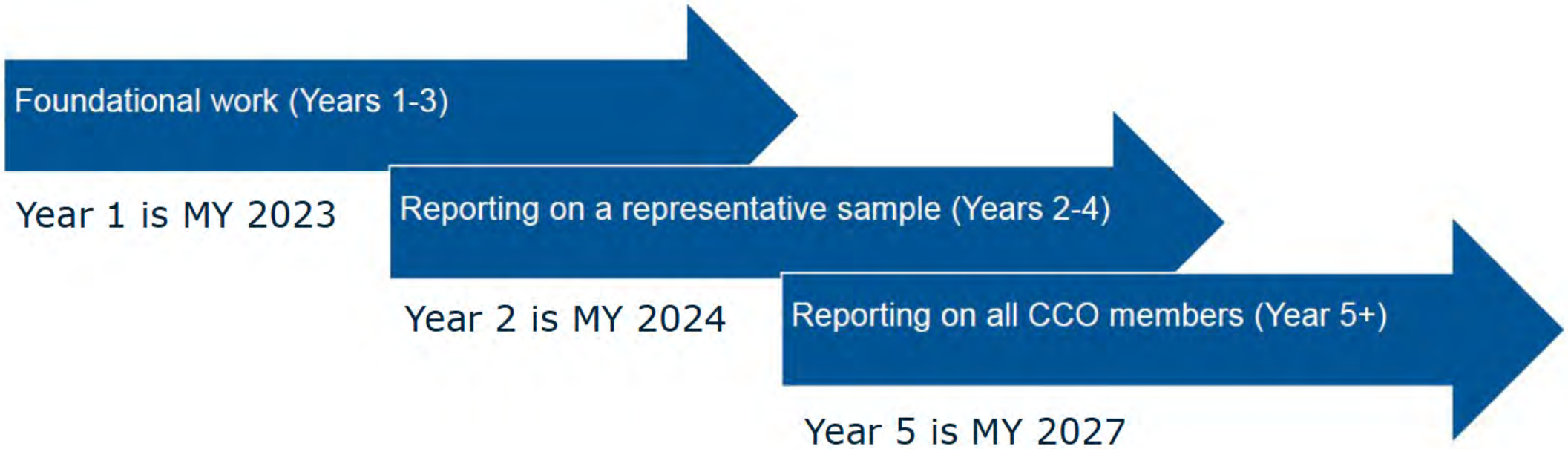


Image from OHA Social Determinants of Health: Social Needs Screening & Referral Measure Educational Webinar presented on March 8, 2022, at Metrics & Scoring Committee.

The social needs screening and referral measure would phase in over time



OHA Project #61, #33

MY = Measurement Year

Image from OHA Social Determinants of Health: Social Needs Screening & Referral Measure Educational Webinar presented on March 8, 2022, at Metrics & Scoring Committee.

OHA Incentive Metric

Glide path that starts with **structural measure** (Component 1; CCO self-assessment) in Year 1 and **then reporting** on a sample of members (Component 2; data in Year 2 and later years

Prevent over-screening

Be Equitable

Build capacity (CBOs)

Basics:

- Screening practices
- Referral practices and resources
- Data collection and sharing

OHA Project #61, #33

3/15/2023

SDOH Screening and Referral

Measure Overview:

- **Social needs (domains) addressed in measure:**
  - Food insecurity
  - Housing insecurity
  - Transportation needs
- **Members included in the measure:**
  - All ages
  - Continuously enrolled for at least 180 days
- **Data sources for numerator credit:**
  - Any (including EHR, CIE, z codes)
- **Must use an approved screening tool**

Component 1 Self-Assessment:

- **15 must-pass elements**
  - Year 1 (MY 2023): 9 must-pass elements
  - Years 2 and 3: 6 more must-pass elements for a total of 15

These slides are based on draft specifications.

OHA Incentive Metric

This measure creates opportunity to align existing efforts to address social needs and increase equity.

Later, CCOs start reporting social needs screening and referral data.

SDOH Screening and Referral

To build system capacity, the measure starts by requiring CCOs to:

- Prepare for equitable, trauma-informed, and culturally responsive screening and referrals
- Work with community-based organizations to build capacity for referrals and meeting social needs
- Support data sharing between CCOs, providers, and community-based organizations

The measure requires CCOs to work directly with providers and non-provider organizations serving community to:

- Coordinate so members aren't asked the same questions in different places
- Explore options for referrals; identify and fill referral gaps
- Develop a plan to increase referral capacity in the CCO's service area
- Implement an agreement with at least one organization providing services in each of the required domains: food, housing, and transportation

SDOH Screening and Referral OHA Incentive Metric

Component 1: CCO Self-Assessment; Structural Measure

Measurement Year (MY) 1 Must-Pass Elements:

A. Screening Practices:

1. Collaborate with CCO members on processes and policies
2. Establish written policies on training
3. Assess whether/where members are screened
4. Establish written policies to use REALD data to inform appropriate screening and referrals
5. Identify screening tools or screening questions in use
6. Establish written protocols to prevent over-screening

B. Referral practices and resources:

7. Assess capacity of referral resources and gap areas
8. Enter into agreement with at least one CBO that provides services in each of the 3 domains (food, housing, and transportation)

C. Data collection and sharing:

9. Conduct environmental scan of data systems used in your service area

Based on services in place on December 31, 2023.

Year 1 is MY 2023

OHA Project #61, #33

SDOH Screening and Referral OHA Incentive Metric

Component 1: CCO Self-Assessment; Structural Measure

Measurement Years (MY) 2 and 3 Must-Pass Elements:

A. Screening Practices:

10. Assess training of staff who conduct screening
11. Assess whether OHA-approved screening tools are

B. Referral practices and resources:

12. Establish written procedures to refer members to services
13. Develop written plan to help increase community-based organization (CBO) capacity in CCO service

C. Data collection and sharing:

14. Set up data systems to clean and use REALD data
15. Support a data-sharing approach within the CCO service area

Plus, all MY 1 Must-Pass elements.
Based on services in place on December 31 of MY.

Year 2 is MY 2024
Year 3 is MY 2025

Measure Glide Path SDOH Screening and Referral OHA Incentive Metric

Glide path	Year 1	Year 2	Year 3	Year 4	Year 5+
Structural Measure •CCOs prepare to implement in an equitable and trauma-informed way (e.g., input from members, REALD, strategies to avoid rescreening) •CCOs assess capacity and build relationships with community-based organizations •CCOs conduct environmental scan and support data-sharing					
Reporting (sample of CCO population) •CCO reports data on a sample list of members (provided by OHA) •OHA calculates rates based on CCO member-level data submission: (a) screening rate; (b) of those screened, % with need; (c) of those with a need, % with a referral (starts year 3)					
Outcome/ Performance (sample of CCO population) •CCO reports data on a sample list of members (provided by OHA) •OHA calculates rates based on CCO member-level data submission •Benchmark/ to meet measure to be set by Metrics and Scoring Committee o Report (a), (b), (c) o Meet target on (a) - % screened. o TBD if pay-for-performance begins in year 3 or 4					
Goal: Outcome/ Performance (report on full CCO population) Logistical elements (e.g., data submission/ system to capture data) still to be determined					

Year 1 is MY 2023
Year 2 is MY 2024
Year 3 is MY 2025

Year 4 is MY 2026
Year 5 is MY 2027

Image from OHA Social Determinants of Health (SDOH) Measure Summary presented on March 8, 2022, at Metrics & Scoring Committee.

OHA Incentive Metric

Glide path that starts with **structural measure** (Component 1; CCO self-assessment) in Year 1 and **then reporting** on a sample of members (Component 2; data in Year 2 and later years

Prevent over-screening

Be Equitable

Build capacity (CBOs)

Basics:

- Screening practices
- Referral practices and resources
- Data collection and sharing

OHA Project #61, #33

3/15/2023

SDOH Screening and Referral

Component 2 Reporting:

- **Year 2 (MY 2024): 2 rates**
  - **Rate 1:** % of sample who were screened for food insecurity, housing insecurity, AND transportation needs at least once during MY
  - **Rate 2:** Of the sample population screened, % with a positive screen for food insecurity, housing insecurity, OR transportation needs
    - Not intended to be benchmarked
- **Year 3 (MY 2025): add 1 more rate for a total of 3 rates**
  - **Rate 3:** Of the sample population with an identified need, those who received at least one referral
    - Referrals made (not closed loop referrals)
- Years 2-4 are based on a sample population.

Measure is telehealth-eligible.

SDOH Screening and Referral OHA Incentive Metric

Component 2: Data Elements

By member for each domain:

1. **For each domain, was the member screened during the measurement year?**
   - yes, no, member declined screening
2. **If screened, result for each domain of the most recent screening**
   - positive, negative
3. **Approved screening tool used**
4. **Screening location**
   - CCO, clinic, hospital, CBO, other
     - If other screening location, specify
5. **Coding approach**
   - ICD-10 diagnosis Z codes, LOINC, SNOMED, other
     - If other coding approach, specify
6. **Codes used to identify each domain**
   - food insecurity, housing insecurity, and transportation needs
7. **If screening result was positive, was member referred to a resource**
   - yes, no, member declined referral
   - Note: This question is optional in measurement year 2 but will become a required question in measurement years 3-4.
8. **Data source used**
   - claims, charts, EHR, CIE, HIE, case management system, other
     - If other data source, specify

Reporting starts Year 2 (MY 2024) for sample population

Reporting starts Year 5 (MY 2026) for full population

Domains

Food insecurity
Housing insecurity
Transportation needs

Questions: SDOH Screening and Referrals

Be prepared to answer questions similar to these during Q1 2023.

- What screener do you utilize for social needs (i.e. housing, transportation, food insecurity, education, etc.)? (Existing screen (if yes, name?) self made, prescreen, Multiple choice, plus other)
  - Do you use full screen, prescreen, or both?
  - How often full screen?
  - Which population do you screen?
  - Method of screening? Select all that apply.
  - What language is screening available in?
  - Where is data stored?
  - Is the data from the screener used in the decision-making process for referrals?
- Does your organization make referrals for social needs? If so,
  - How do you make referrals? Method? Platform/tool?
  - Please list the most common organizations you refer to and what you refer for (i.e. KLCAS, housing; KLCAS, parenting classes; Food Bank, food insecurity; Klamath Works, clothing; etc.)?
  - Any social needs organizations missing?

Cascade Health Alliance

cascade comprehensive care

Person-Centered Primary Care Home (PCPCH) Comprehensive Plan

In this document, CCC is referenced in place of CCC and CHA.

1 PURPOSE

1.1 Describes the plan CCC will follow to support primary care clinics with PCPCH tier advancement and increase CHA member enrollment in higher PCPCH clinics.

1.2 Describes how CCC will align efforts with PCPCH standards when collaborating with PCPCH clinics.

2 SCOPE

2.1 Includes CCC staff, CCC members, and PCPCH clinics.
2.2 Includes a learning collaborative with technical assistance (TA) opportunities, member education, and value-based payments.

3 PROCESS

3.1 PCPCH Learning Collaborative – Utilize a PCPCH learning collaborative to share best practices and align efforts to improve member experience.
- 3.1.1 Develop, test, review, implement, and establish learning collaborative structure.
  - 3.1.1.1 Prioritize topics/standards in the following order:
    - 3.1.1.1.1 Degree of alignment with other CCC initiatives
    - 3.1.1.1.2 Degree of relation to member experience
    - 3.1.1.1.3 Topics/standards PCPCH clinics struggle with
  - 3.1.1.2 Create schedule for six (6) months at a time.
    - 3.1.1.2.1 Included as standing agenda item during Metrics Workgroup.
    - 3.1.1.2.2 Meetings are held monthly with the intent that 100% of PCPCH clinics participate.
      - 3.1.1.2.2.1 The learning collaborative targets current PCPCH clinics while encouraging the participation of other network providers (non-PCPCH primary care, specialty, behavioral health, and oral health providers).
  - 3.1.1.3 Technical assistance (TA) opportunities are offered as needed.
- 3.1.2 Quarterly article submissions the Care Talk provider newsletter will relate to topics discussed during learning collaborative meetings.

3.2 PCPCH Member Education - Develop and use member education materials to increase member awareness of the benefits of belonging to a PCPCH for improving patient care and health outcomes.
- 3.2.1 PCPCH information is included in the CHA Member Handbook.
- 3.2.2 Develop PCPCH pamphlet.
  - 3.2.2.1 QM review and approve PCPCH pamphlet.
  - 3.2.2.2 Community and Public Relations, OHA, and others if needed review and approve PCPCH pamphlet.
  - 3.2.2.3 PCPCH pamphlet printed by vendor in color or internally in black and white.
    - 3.2.2.3.1 The goal is for 100% of new members are sent pamphlet in new member packets for three months.
      - 3.2.2.3.1.1 After three months, QM will evaluate if printed pamphlets are effective and if CCC should continue using pamphlets.
- 3.2.3 Add PCPCH information to CCC website.
- 3.2.4 Create, review, and approve PCPCH text.
  - 3.2.4.1 Text includes link to PCPCH information on CCC website.
  - 3.2.4.2 Send text to all CHA members with physical health coverage.

3.3 PCPCH Value-Based Payments – CHA's Value-Based Payment model includes a tiered-bonus payment for PCPCH certification, starting at the tier-3 level with increasing payments to the 5 Star level.

3.4 Review PCPCH Comprehensive Plan annually and update as needed.

4 APPENDIX <or APPENDICES> <delete if not required>

4.1 CHA Member Handbook: https://www.cascadehealthalliance.com/for-members/member-handbook/
4.2 CHA Website PCPCH: https://www.cascadehealthalliance.com/for-members/member-benefits/patient-center-primary-care-homes-pcpch/
4.3 PCPCH: https://www.oregon.gov/oha/hpa/dsi-pcpch/Pages/index.aspx
4.4 Transformation and Quality Strategy (TQS): https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy.aspx
4.5 TQS Technical Assistance (TA): https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy-Tech-Assist.aspx

PATIENT CENTERED PRIMARY CARE HOME POLICY AND PROCEDURE

In this document, CCC is referenced in place of CCC and CHA.

CONTENTS

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Terms not defined in the DEFINITIONS section of this document may be found in the CCC Glossary.

1 PURPOSE

1.1 This policy and procedure establishes standards to ensure members receive access to integrated, culturally and linguistically appropriate patient-centered care and services (physical, behavioral, and dental).

2 SCOPE

2.1 This policy acts as a guide to assure that Members are fully informed partners in transitioning to and maximizing the benefits of the Patient-Centered Primary Care Home (PCPCH) model of care.

3 POLICY STATEMENT

3.1 Member Services Department will:

3.1.1 Provide each Primary Care Provider (PCP)/PCPCH with a current member assignment/reassignment list daily.

4 PROCEDURE

4.1 The Medical Director will:

4.1.1 Contact each provider/clinic regularly to determine total number of enrollees they will accept based on provider availability.

4.1.2 Monitor local and out of area needed specialists for availability and access.

4.2 PCP/PCPCH will:

4.2.1 Provide written notice to CHA at least 90 days prior, of provider's intent to close his/her practice to all new patients.

4.2.2 Providers may not close his/her practice to new members while continuing to accept new patients from other plans, if they have not filled their agreed upon capacity with CHA.

5 RESPONSIBILITIES

5.1 If we intend to terminate a health care provider or group, resulting in a significant impact on access to care, we will give Oregon Health Authority (OHA) 90 days' notice prior to the date of termination. If a provider or group is going to terminate and fails to provide the required 90 days' notice or there are problems that could compromise member care, we will give notice to OHA as soon as information is available.

Compliance, Monitoring and Review

5.2 The Member Services department will monitor the provider panel for access to primary care and specialty care on a monthly basis. This includes identifying availability of cultural and linguistic capabilities of provider/staff, the number of enrollees the provider is currently serving and the additional capacity for new enrollees.

5.3 The Compliance Management department will monitor the complaint logs for issues regarding PCP/PCPCH choice, assignment and reassignment.

5.4 The Executive Approval Committee will review this policy and procedure for compliance with OHA contract and guidelines at least once a year, or as applicable.

Reporting

5.5 The Compliance Department will conduct access and appropriateness of care audits for each PCP/PCPCH and/or clinic on an annual basis.

Records Management

5.6 Team Members must maintain all records relevant to administering this policy and procedure in the recognized record management system.

6 DEFINITIONS

7 RELATED LEGISLATION AND DOCUMENTS

7.1 Contract # 143110-11

7.2 Health Insurance Portability and Accountability Act (HIPAA)

7.3 Oregon Health Authority (OHA): Coordinated Care Organizations (CCO)

8 FEEDBACK

8.1 Team Members may provide feedback about this document by emailing policyfeedback@cascadecomp.com.

9 APPROVAL AND REVIEW DETAILS

Approval and Review	Details
Advisory Committee to Approval	Executive Approval Committee
Committee Review Dates	10/10/2018
Approval Dates	10/15/2018

Cascade Health Alliance

cascade comprehensive care

Medication Therapy Management (MTM) PROCESS

In this document, CCC is referenced in place of CCC and CHA.

1 PURPOSE

1.1 The purpose of the Medication Therapy Management process is to reduce drug therapy issues (polypharmacy, interactions, appropriate use, and formulary management), educate members regarding their medications and disease states, and to work towards mutually agreed upon goals with members (as well as providers) to promote success in management of chronic disease states.

2 SCOPE

This process will involve working with the member, the member's provider(s), and the pharmacy team at CHA. Pharmacists administering MTM will meet the following qualifications:

Current license as a Registered Pharmacist with the state of Oregon

Either prior experience as an MTM pharmacist or MTM certification through an approved Continuing Education (CE) course. Approval will be determined by the Director of Pharmacy services.

Certification in any (or all) of the following are desirable, but not required. The expectation will be that the pharmacist working in this process will engage in obtaining certification in at least one of these areas: Diabetes, Asthma, Dyslipidemia, and Anticoagulation.

3 PROCESS

Members will be recruited by disease state. Initial qualifications are for members with Diabetes Type II, with an A1c above target.

This list will be developed from data sets obtained from Quality Management.

Pharmacy will then reduce the list based on eligibility (may not be eligible under other programs, may not be Type 1) and A1c measurement.

Members will be contacted to schedule an appointment date and time for a complete medication review, performed over the telephone

Once the meeting has been started, pharmacist will conduct the review using the attached interview information suggestion guide. All members will be confirmed via date of birth.

Research will be done as far as is possible using the member's medical history chart in Epic, the member's medication purchase through and information that can be obtained through

Initial appointments will last 1 hour in duration. Follow up visits will last 15 to 30 minutes in length, with each subsequent visit optimally shorter in length.

The provider will be the source of all exams, lab orders, and diagnostics. Providers must be in agreement with the rationale for making changes in medication therapy.

Each member will be contacted by phone for the pre-arranged appointment, worked with to confirm date of birth, disease states, and medications currently in use. Each medication will be discussed with the member, to include if the medications are being used consistently, what else has been tried, and what the barriers to care are for this specific member. Pharmacist will then identify barriers to care with the member, and work towards reducing/eliminating them. This may involve contacting other departments, such as Case Management, putting the member in touch with 'Aunt Bertha' (a services data base), etc. All reportable

events that are uncovered during the MTM process will be reported to the correct department (abuse of the member such as child or elder abuse as an example).

At completion of each MTM appointment, the pharmacist will go over what has been discussed with the member, with recommendations if there are any. The pharmacist will then produce a member letter, a provider letter (irrespective of recommendations, the provider should be informed of this service and the outcome), and a full and current medication list to be provided to each of them.

Recommendations can be followed up with on next scheduled visit, or sooner if warranted.

4 APPENDIX <or APPENDICES

CCC MTM template

Date

Appointment number (initial, follow up by number, etc)

Any relevant info here, such as inability to contact, number of attempts, etc.

Patient Name

Gender Identity

DOB CCC ID:

Contact info on file:

Phone number:

Address:

ALLERGIES:

Provider:

Current Health status – comorbidities, unwell today, etc

Source?

Tobacco use?

Any other medications used (marijuana, methamphetamine, etc)

HbA1c : date obtained, and any relevant medical history here

Other relevant labs

Current Med List

Source (Epic, patient,

Recommendations:

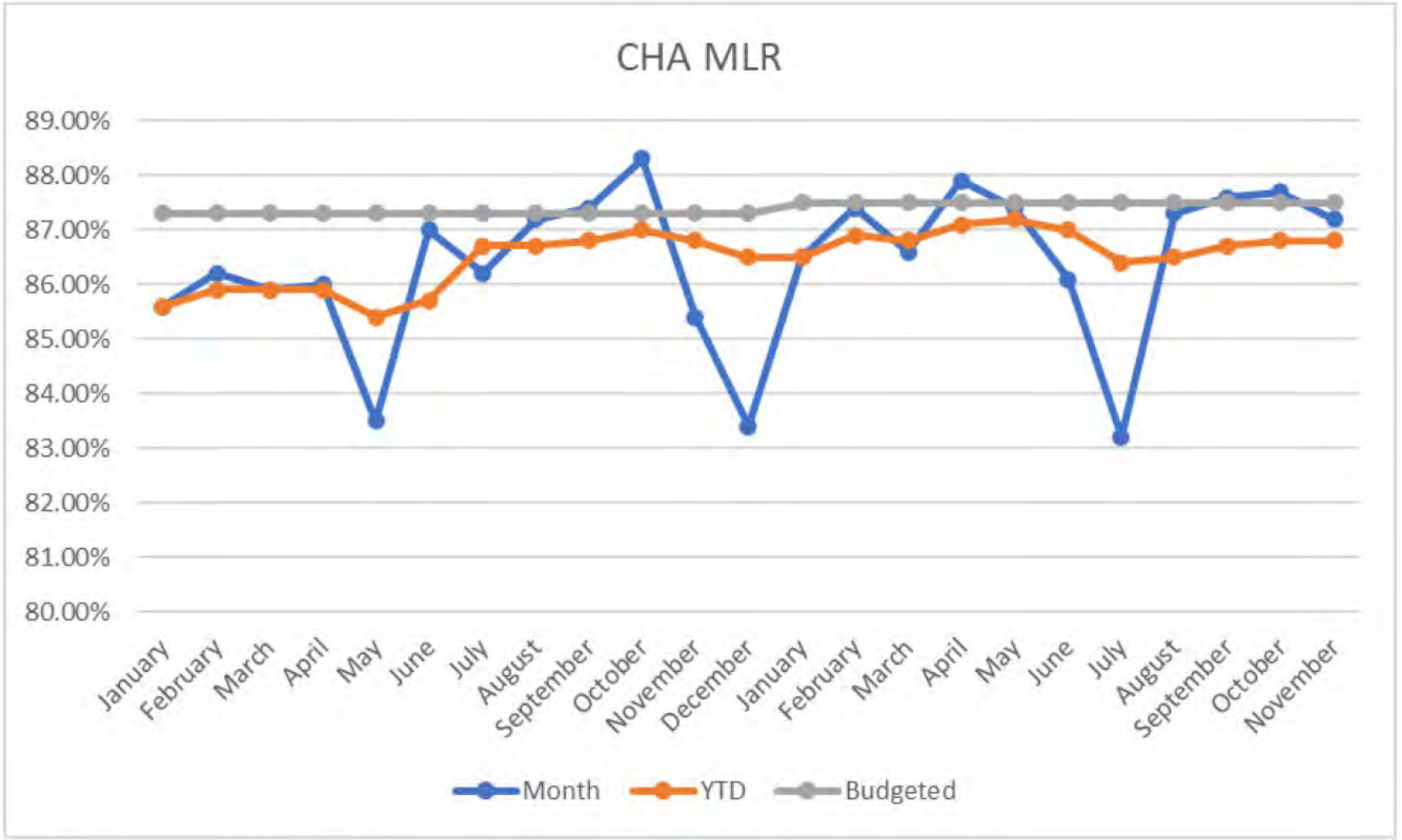
Duplicate med class? Consistent use? If not, why is this a factor for this person? Accessibility, affordability, storage issues (homeless?), cultural issues with meds? Identify barriers to care, including cultural approaches to med use

MTM pharmacist _____Duration of appt.

Member Spend narrative

January 2023

CHA Medical Loss Ratio Through September 2022



OHA Projects #366, #59

- MRL shows expected month to month variation and is under budget year to date

CHA Member Spend Summary

CHA MEMBER SPEND YEAR-OVER-YEAR

Cascade Health Alliance

12/31/2022
David Shute

Summary

2020	2021	2022	2022 vs. 2021
23,548	25,793	27,882	Spend | ▲ 10.3%
Spend/MM |	Spend/MM |	Spend/MM |	Members | ▲ 8.1%
			Spend/MM | ▲ 1.7%

Bucket Details Summary

	Spend YTD	Members YTD	Spend/Member YTD
$25k+	▲ 21.5%	278 ▲ 13.9%	
$10,000 - $24,999	▲ 3.9%	632 ▲ 4.3%	
$1,000 - $9,999	▲ 5.2%	5,711 ▲ 7.5%	
$0-$999	▲ 8.6%	11,330 ▲ 4.2%	
No Claim		9,931 ▲ 13.4%	

Date Ranges: 1/1/2020 - 9/30/2020, 1/1/2021 - 9/30/2021, 1/1/2022 - 9/30/2022 **Data extracted:** 12/25/2022 **Data Source:**
- Spend/MM calculates total spend for time period and dividing by total member months for the same time period

- Report does not include capitated payments but does include claims for capitated services
- Spend PMPM is up 1.7% YOY through the end of September
- There is an 8% increase in members with a 14% increase in high-cost members
- 35% of members have no claims activity

CHA Member Spend by Claim Type

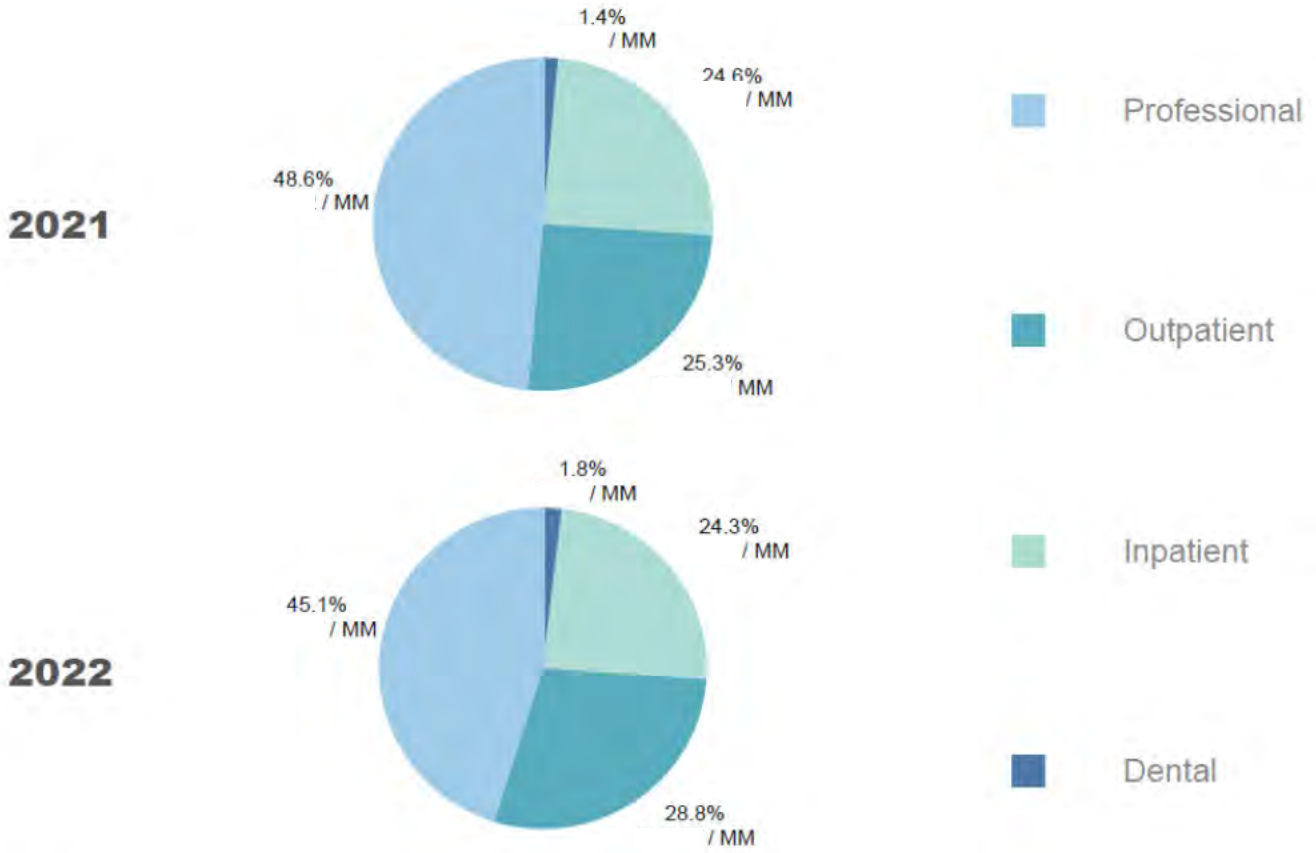
CHA MEMBER SPEND YEAR-OVER-YEAR

Cascade Health Alliance

12/31/2022
David Shute

Spend By Claim Type

Percent of total dollars spent in professional, inpatient, outpatient, and dental claim types for 2021 and 2022	Change in spend per member month for each category between 2021 and 2022



Date Ranges: 1/1/2020 - 9/30/2020, 1/1/2021 - 9/30/2021, 1/1/2022 - 9/30/2022 **Data extracted:** 12/25/2022 **Data Source:**
- Spend/MM calculates total spend for time period and dividing by total member months for the same time period

- Percent of spend from professional services has decreased by 3.5% YOY
- Percent of spend from outpatient services has increased by 3.5% YOY
- Percent of spend from inpatient services has decreased by 0.3% YOY

CHA Member Spend – Professional Spend

CHA MEMBER SPEND YEAR-OVER-YEAR

Cascade Health Alliance

12/31/2022
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Professional Spend

Professional claims account for 45.1% of total spend in through September 2022

2020	2021	2022	2022 vs. 2021
14,226 Members	**16,482** Members	**17,132** Members	Members | ▲ **3.9%**
spent across	spent across	spent across	Spend | ▲ **2.4%**
194,889 Professional claims	**220,937** Professional claims	**222,722** Professional claims	Claims | ▲ **0.8%**
Professional Spend/MM |	Professional Spend/MM |	Professional Spend/MM |	Spend/MM | ▼ **5.5%**

Professional Spend Bucket Details

	Spend YTD	Members YTD	Claims YTD	Spend/Member YTD
$25k+		47	7,188	
$10,000 - $24,999		231	23,596	
$1,000 - $9,999		4,323	113,901	
$0-$999		12,531	78,037	

Date Ranges: 1/1/2020 - 9/30/2020, 1/1/2021 - 9/30/2021, 1/1/2022 - 9/30/2022 **Data extracted:** 12/25/2022 **Data Source**
- Spend/MM calculates total spend for time period and dividing by total member months for the same time period

- Professional spend has decreased by 5.5% PMPM YOY
- Decreased Professional PMPM is due to decreased cost per claim

CHA Member Spend – Inpatient Spend

CHA MEMBER SPEND YEAR-OVER-YEAR

Cascade Health Alliance

12/31/2022
David Shute

Inpatient Spend

Inpatient claims account for 24.3% of total spend in through September 2022

2020	2021	2022	2022 vs. 2021
890 Members	**912** Members	**944** Members	Members | ▲ **3.5%**
spent across	spent across	spent across	Spend | ▲ **8.6%**
1,129 Inpatient claims	**1,194** Inpatient claims	**1,176** Inpatient claims	Claims | ▼ **1.5%**
Inpatient Spend/MM |	Inpatient Spend/MM |	Inpatient Spend/MM |	Spend/MM | ▲ **0.1%**

Inpatient Spend Bucket Details

	Spend YTD	Members YTD	Claims YTD	Spend/Member YTD
$25k+		115	232	
$10,000 - $24,999		155	212	
$1,000 - $9,999		542	587	
$0-$999		132	145	

Date Ranges: 1/1/2020 - 9/30/2020, 1/1/2021 - 9/30/2021, 1/1/2022 - 9/30/2022 **Data extracted:** 12/25/2022 **Data Source:** Plexis
- Spend/MM calculates total spend for time period and dividing by total member months for the same time period

- Inpatient spend PMPM in unchanged compared to 2021 and decreased 22% compared to 2020
- Highest cost members are averaging 2 inpatient claims through 9/30/22

CHA Member Spend – Outpatient Spend

CHA MEMBER SPEND YEAR-OVER-YEAR

Cascade Health Alliance

12/31/2022
David Shute

Outpatient Spend

Outpatient claims account for 28.8% of total spend in through September 2022

2020	2021	2022	2022 vs. 2021
8,254 Members	**9,304** Members	**10,279** Members	Members | ▲ **10.5%**
spent across	spent across	spent across	Spend | ▲ **25.1%**
53,341 Outpatient claims	**65,343** Outpatient claims	**68,457** Outpatient claims	Claims | ▲ **4.8%**
Outpatient Spend/MM |	Outpatient Spend/MM |	Outpatient Spend/MM |	Spend/MM | ▲ **15.4%**

Outpatient Spend Bucket Details

	Spend YTD	Members YTD	Claims YTD	Spend/Member YTD
$25k+		38	1,235	
$10,000 - $24,999		126	2,806	
$1,000 - $9,999		2,018	23,246	
$0-$999		8,097	41,170	

Date Ranges: 1/1/2020 - 9/30/2020, 1/1/2021 - 9/30/2021, 1/1/2022 - 9/30/2022 **Data extracted:** 12/25/2022 **Data Source:** Plexis
- Spend/MM calculates total spend for time period and dividing by total member months for the same time period

- Outpatient spend is up 15% PMPM
- Increased PMPM is mostly due to increased cost per claim

CHA Member Spend – Dental Spend

CHA MEMBER SPEND YEAR-OVER-YEAR

Cascade Health Alliance

12/31/2022
David Shute

Dental Spend

Dental claims account for 1.8% of total spend in through September 2022

2020	2021	2022	2022 vs. 2021
1,154 Members	**1,223** Members	**2,097** Members	Members | ▲ **71.5%**
spent across	spent across	spent across	Spend | ▲ **41.3%**
3,265 Dental claims	**3,932** Dental claims	**7,016** Dental claims	Claims | ▲ **78.4%**
Dental Spend/MM |	Dental Spend/MM |	Dental Spend/MM |	Spend/MM | ▲ **30.3%**

Dental Spend Bucket Details

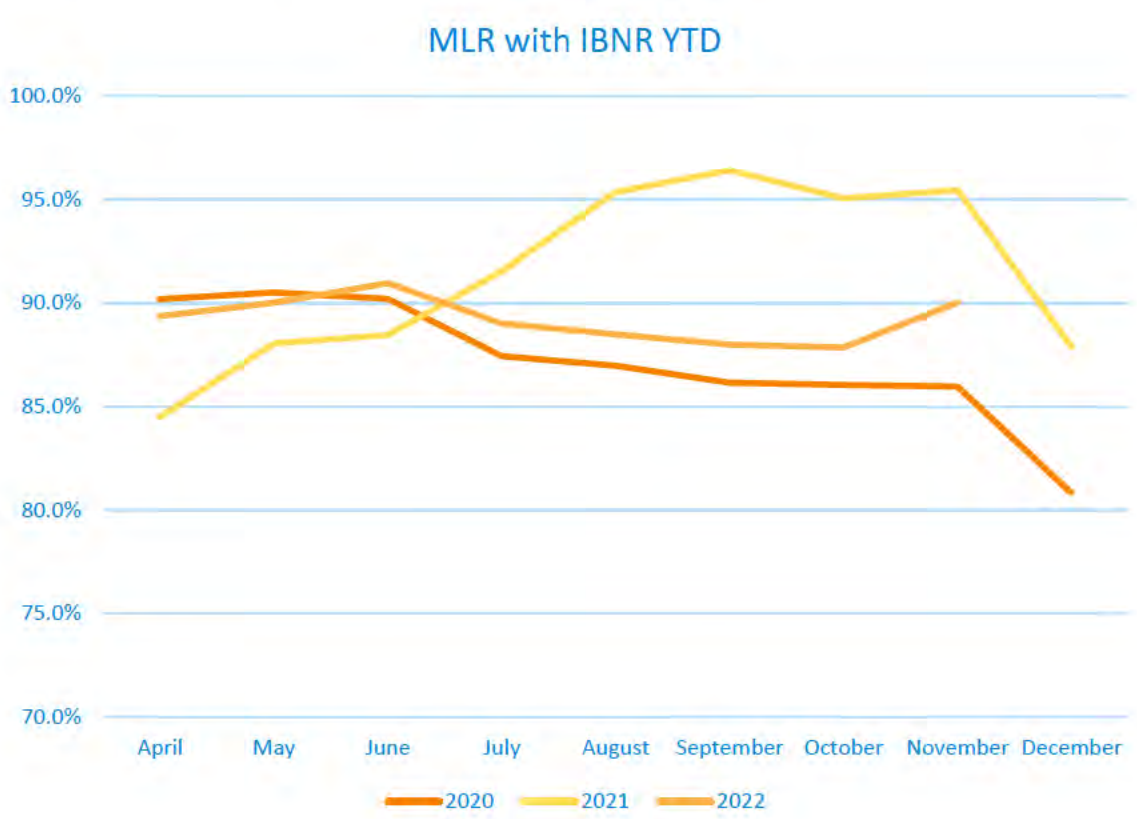
	Spend YTD	Members YTD	Claims YTD	Spend/Member YTD
$1,000 - $9,999		370	1,522	
$0-$999		1,727	5,494	

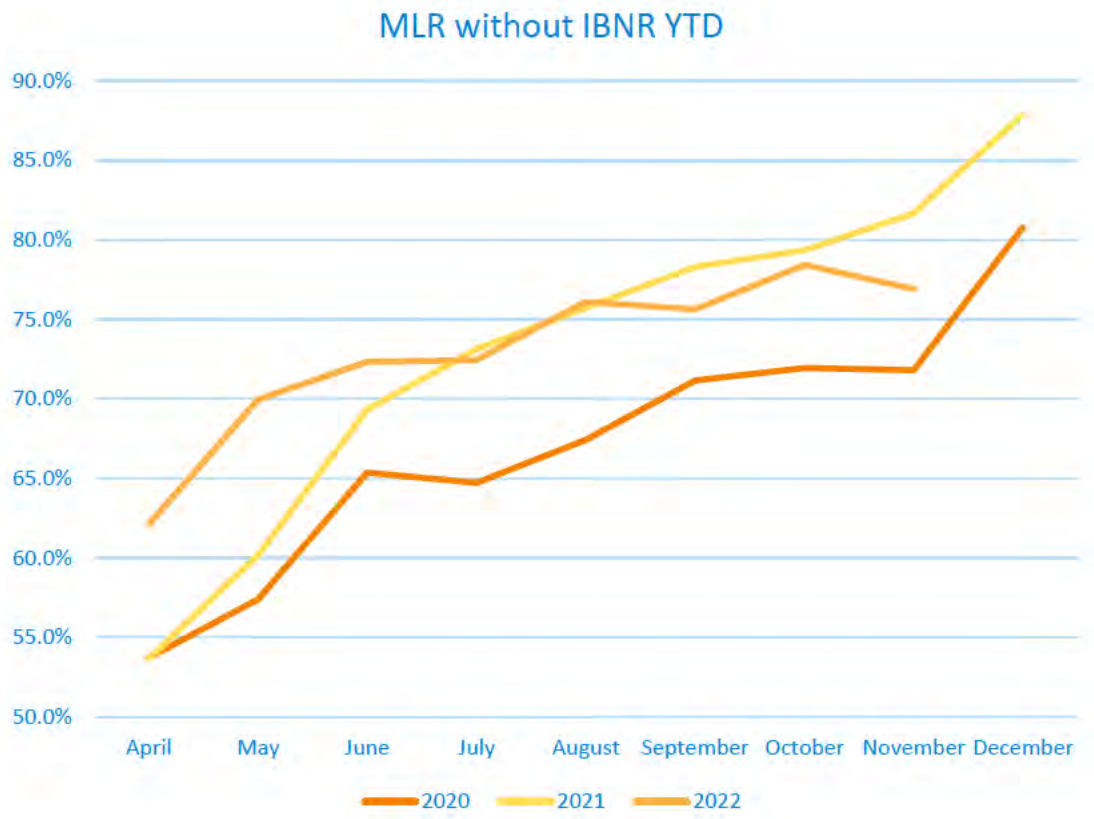
Date Ranges: 1/1/2020 - 9/30/2020, 1/1/2021 - 9/30/2021, 1/1/2022 - 9/30/2022 **Data extracted:** 12/25/2022 **Data Source:**
- Spend/MM calculates total spend for time period and dividing by total member months for the same time period

- Capitated payments are not included in the report
- Dental spend is up by 30% PMPM compared with 2021
- Members utilizing non-capitated services have increased 72% since 2021
- Decreased utilization during COVID and deferred care are likely contributing to the large percentage increases

Atrio Medical Spend – This is Novembers in case you are able to add and edit it again

ATRIO Medical Loss Ratio





MLR including IBNR has increased this month due to higher IBNR estimates as determined by ATRIO

YTD MLR performance including IBNR has improved 5.5% compared with 2021

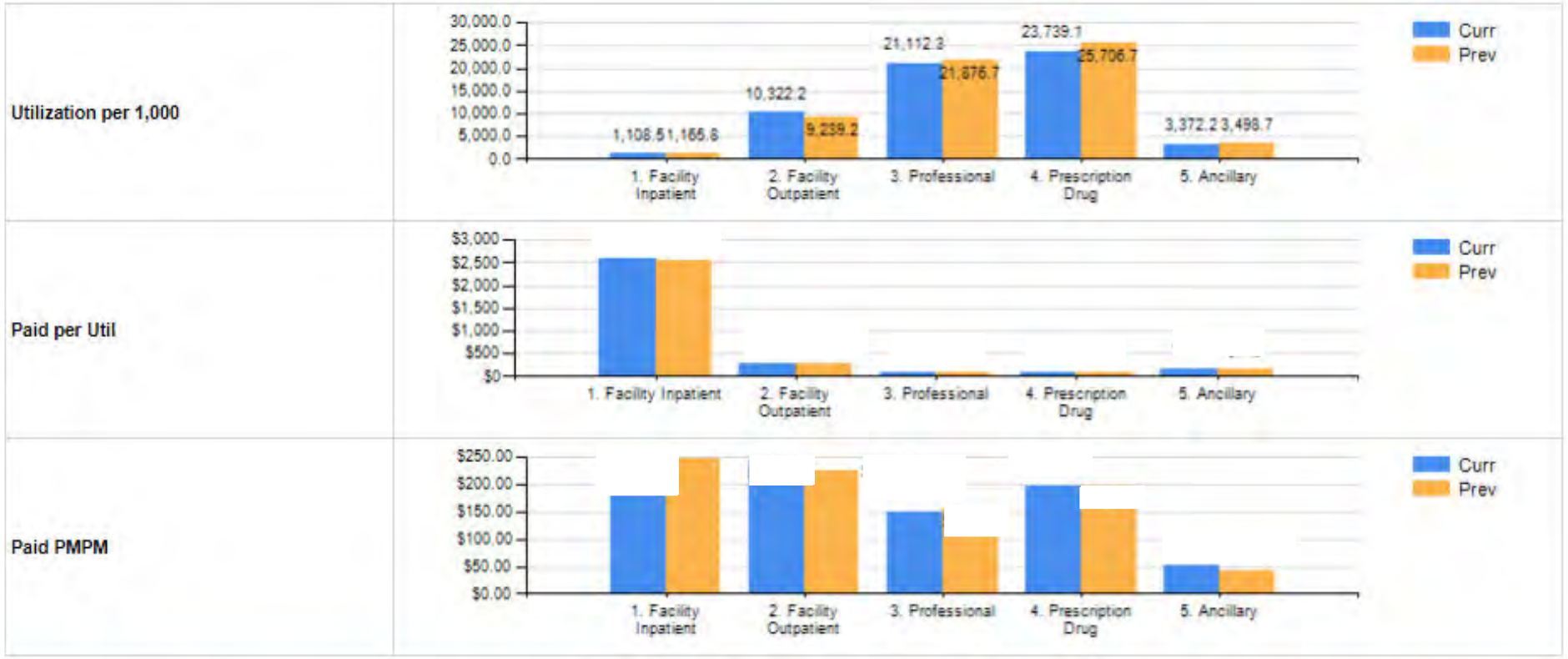
YTD MLR performance excluding IBNR has improved 4.8% compared with 2021

Historically, MLR decreases during claims run out due to overestimated IBNR

Atrio Utilization Trend With Estimated IBNR

Incurred 2022-01 to 2022-12
Incurred Comparison 2021-12 to 2021-12
HCG Setting All
Gender All **Age Band** All
Unfiltered Group Name, SAC, Benefit Plan, Region, Plan Number, Contract Id, Product Line, Account Type

IBNR estimates may be high



OHA Projects #366, #59

Atrio Utilization Trend With Estimated IBNR

- PMPM trend shows an overall 1.5% increase in 2022
- Outpatient and ancillary costs are increased while inpatient and professional have decreased

HCG Comparison
Complete

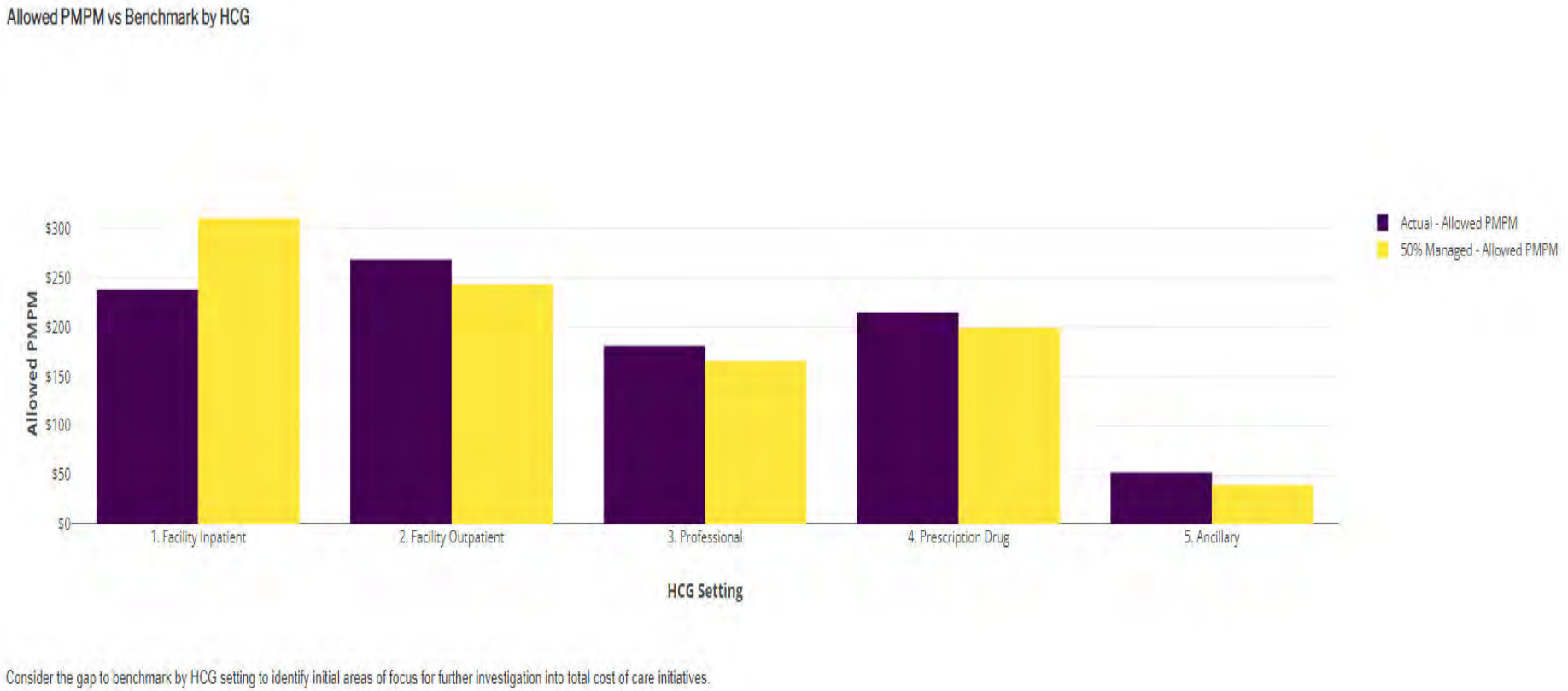
Incurred 2022-01 to 2022-12
Incurred Comparison 2021-01 to 2021-12
HCG Setting All
Gender All **Age Band** All
Unfiltered Group Name, SAC, Benefit Plan, Region, Plan Number, Contract Id, Product Line, Account Type

HCG Categories	Utilization per 1,000			Paid per Util			Paid PMPM		
	Curr	Prev	Trend	Curr	Prev	Trend	Curr	Prev	Trend
⊞1. Facility Inpatient	1,108.5	1,165.8	-4.9%			1.9%			-3.1%
⊞2. Facility Outpatient	10,322.2	9,239.2	11.7%			-2.5%			8.9%
⊞3. Professional	21,112.3	21,876.7	-3.5%			-0.6%			-4.1%
⊞4. Prescription Drug	23,739.1	25,706.7	-7.7%			8.2%			-0.1%
⊞5. Ancillary	3,372.2	3,498.7	-3.6%			20.8%			16.4%
Grand Total	59,654.3	61,487.0	-3.0%			4.6%			1.5%

Health Cost Guideline (HCG): a proprietary healthcare cost and utilization categorization scheme developed by

OHA Projects #366, #59

ATRIO Cost Performance vs. 50th Percentile Managed Care Benchmark



- 2021-09 to 2022-09 allowed expenses (offset 3 months)
- Costs are above 50% benchmark for all settings except for inpatient

OHA Projects #366, #59

Allowed Cost by Setting Vs 50th percentile Benchmark

- Costs are for a rolling 12-month period incurred from 2021-09 to 2022-09 (offset 3 months)
- Total cost are PMPM under benchmark
- Prescription drug costs are PMPM over benchmark
- Inpatient costs are PMPM under benchmark

Allowed PMPM vs Benchmark by HCG Detail

	Allowed PMPM	50% Managed Allowed PMPM	Allowed to Benchmark Difference
Grand Total			
+ 1. Facility Inpatient			
+ 2. Facility Outpatient			
+ 3. Professional			
+ 4. Prescription Drug			
+ 5. Ancillary			

Spend by Hierarchical Chronic Condition Groupers

CCHG Summary
Incomplete

Incurred 2022-01 to 2022-12
Paid 2016-01 to No Paid Date
HCG Setting All
Gender All **Age Band** All
Unfiltered Group Name, SAC, Benefit Plan, Region, Plan Number, Contract Id, Product Line, Account Type

CCHG	Member Months		Allowed		Allowed PMPM
		% Total		% Total	
⊟Chronic Condition	51,274	78.10%		96.83%	
101 - Major psychosis	1,344	2.05%		4.75%	
102 - Severe dementia	2,135	3.25%		4.59%	
103 - Cancer	4,405	6.71%		16.84%	
104 - Renal failure and/or post kidney transplant	3,220	4.90%		12.59%	
105 - Liver disease (Hepatitis, Cirrhosis) - post transplant	947	1.44%		3.36%	
106 - HIV	39	.06%		.34%	
107 - Severe rheumatic & other connective tissue disease	1,257	1.91%		2.90%	
108 - Severe heart failure/transplant/rheumatic heart disease/non-rheumatic valvular heart disease	5,222	7.95%		12.30%	
109 - Hemophilia & sickle cell & chronic blood disorders	318	.48%		.87%	
110 - Both CAD & diabetes	931	1.42%		2.49%	
111 - CAD without diabetes	1,901	2.90%		2.87%	
112 - Diabetes without CAD	6,129	9.34%		9.28%	
113 - Hypertension (includes stroke & peripheral vascular disease)	11,431	17.41%		11.77%	
114 - COPD	1,029	1.57%		1.50%	
115 - Asthma	1,007	1.53%		1.22%	
116 - Neurologic disorders	1,307	1.99%		1.73%	
118 - Congenital anomalies	83	.13%		.08%	
120 - Chronic musculoskeletal/osteo arthritis/osteoporosis	2,560	3.90%		2.75%	
121 - Depression, substance abuse and other mental health disorder	1,147	1.75%		.83%	
122 - Gastrointestinal disorders	402	.61%		.34%	
123 - Thyroid disorders	898	1.37%		.38%	
124 - Dermatologic disorders	59	.09%		.02%	
126 - Other chronic conditions	3,503	5.34%		1.26%	
⊞Healthy	14,381	21.90%		2.65%	
⊞No CCHG Grouping		.00%		.32%	
Total	65,666				

Health Cost Guideline (HCG): a proprietary healthcare cost and utilization categorization scheme developed by Milliman

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CCHG Summary

- 97% of costs are attributed to members with one or more chronic conditions
- 19% of costs are attributed to members with cancer
- 13% of costs are attributed to members with renal failure or post kidney transplant
- 12% of costs are attributed to members with heart failure, heart transplant or valvular disease

Cascade Health Alliance

cascade comprehensive care

ATRIO CHA Collaborative Workflow

In this document, CCC is referenced in place of CCC and CHA.

1 PURPOSE

1.1 The purpose of this workflow is to create a pathway for collaborative communication between Atrio and CHA Case Management (CM) around dual eligible special needs population (DSNP) members who may need case management services from both. It will include referrals to CHA CM from Atrio and sharing of Health Risk Assessments (HRAs), Care plans, and contact and progress notes between the two lines.

1.2 This workflow enables CHA and Atrio CM to prioritize members receiving long-term services and supports (LTSS).

1.3 This workflow includes service provision, coordination, follow up, and monitoring of members.

1.4 This workflow will enhance the reduction of duplication of services (including services related to discharge planning for short-term and long-term hospital and institutional stays).

2 SCOPE

2.1 Collaboration related to case management and data sharing between Atrio Health Plans (Atrio) and Cascade Comprehensive Care (CCC).

- 2.1.1 Atrio is a Medicare Advantage (MA) organization with Preferred Provider Organization (PPO) plans and Dual Eligible Special Needs Plans (DSNP).
- 2.1.2 CCC is a health care management company that operates Klamath County's coordinated care organization (CCO), Cascade Health Alliance (CHA), and serves as a local administrator for Atrio.

2.2 Case management department at CCC.

- 2.2.1 The case management department at CCC includes CHA and Atrio staff.

2.3 Coordination includes, but is not limited to, the identification of barriers to care, coordination with the member's PCP and other applicable parties, medical treatment plan compliance, medication compliance, disease-specific teaching, and identification of social determinant of health needs.

2.4 This workflow focuses on DSNP members, a subpopulation of CHA's Full Benefit Dual Eligible (FBDE) population.

- 2.4.1 DSNP members have both CHA and Atrio insurance.
- 2.4.2 DSNP population includes members with special health care needs (SHCN), including but is not limited to long-term services and supports (LTSS).
  - 2.4.2.1 The LTSS population is a subpopulation of the LTSS members captured through CHA Memorandum of Understanding (MOU) reporting.
- 2.4.3 Any FBDE member could potentially because a DSNP member.

3 PROCESS

3.1 Referral to CHA CM from Atrio

- 3.1.1 Atrio CM identifies DSNP member with intensive care coordination needs.
  - 3.1.1.1 High health care needs

3.1.1.2 Multiple chronic conditions
3.1.1.3 Mental illness or substance abuse disorders
3.1.1.4 Functional disabilities or live with health or social conditions that place them at risk of developing functional disabilities
3.1.1.5 LTSS members who otherwise meet Special Health Care Need (SHCN) population as defined by the OAR
3.1.1.5.1 APD notifies CHA monthly who the CHA LTSS members.
3.1.1.5.2 Using APD's insurance flag, CHA sends Atrio a monthly list to identify who the DSNP LTSS members are
3.1.1.5.3 Atrio identifies if Atrio CM or CHA CM needs to actively engage with DSNP LTSS member

3.1.2 Referral for CHA case management is emailed to Clinical Operations Manager and CCC Director of Clinical Operations, with attached copy of most recent Atrio HRA.
3.1.3 Summary of member needs will be included in referral.
3.1.4 Atrio CM documents in Atrio Member chart that referral has been placed to CHA for on-going case management.

3.2 CM and UM Manager will assign referral to CHA CM, upload the HRA to the member CHA CM chart.
3.3 CHA Case Manager will verify acceptance of referral, and channel of communication through email or Teams will be opened between Atrio/CHA CMs.
3.4 CM will process referral according to standard case management pathways, beginning with screening.
3.4.1 The purpose of attaching the Atrio HRA is to allow CHA CM to review and prefill CHA HRA with existing information to not duplicate the query with the member.
3.5 Comprehensive data monitoring and analysis plan to include, but is not limited to:
3.5.1 Outreach efforts and members engaged in services
3.5.2 Services provided. Care plan/goals are developed.
3.5.3 Members served and being actively case managed
3.5.4 ED utilization
3.5.5 Depression Screening and Follow-up
3.5.6 Plan All-Cause Readmissions
3.5.7 Change of condition (drastic)
3.5.8 Chronic diseases (including, but are not limited to, diabetes, congestive heart failure, asthma, and COPD) and complications of and health outcomes related to those chronic diseases)
3.6 Mutual accessibility to all necessary member information and reporting.
3.6.1 CHA CM attends all IDT meetings. Atrio CM is invited to all IDT meetings.
3.6.2 Care plan is emailed to Atrio CM monthly or as applicable.
3.6.3 Case closure and reasons for closure.
3.6.3.1 Atrio CM will add these notes and updates to the Atrio chart as a valid action.
3.6.4 Atrio CM will share additional information with CHA CM as applicable.
3.7 All collaborative care between CHA and Atrio CM will aid in further development related to:
3.7.1 Identification of improvement opportunities to improve health outcomes, target health disparities, reduce all-cause readmissions, increase screening for depression and follow-up, and decrease avoidable emergency room utilization

3.7.2 Formal staff training curriculum development based on Atrio's SNP Model of Care (MOC)
3.7.3 Mutual accessibility to all necessary member information and reporting
3.7.4 Regular review of current processes and workflows for service provision, coordination, follow up, and monitoring of members
3.7.5 Streamlining processes to improve data capture, contact with and screening of LTSS and other SHCN members, and care coordination as well as standardize communication.